

The Scottish Roots of the National Health Service

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DECLARATION

This thesis has been composed entirely by myself.

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ABBREVIATIONS

BHA	British Hospitals Association
BMA	British Medical Association
BMJ	British Medical Journal
CAB	Cabinet
DC	University of Glasgow Archive
HC	House of Commons
EHS	Emergency Hospital Scheme
EMS	Emergency Medical Service
HIMS	Highlands and Islands Medical Service
IMR	Infant Mortality Rate
LCC	London County Council
LH	Lothian Health Board Archive
MMR	Maternity Mortality Rate
MOH	Medical Officer of Health
NAS	National Archives of Scotland
NHI	National Health Insurance
NHS	National Health Service
PEP	Political and Economic Planning
PRO	Public Record Office
RCPE	Royal College of Physicians of Edinburgh
SCEC	Scottish Central Emergency Committee

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INTRODUCTION

There are two National Health Services in Britain. The National Health Service Act, 1946 that set up the National Health Service in England and Wales did not apply to Scotland. The National Health Service that came into being in Scotland on the 5 July 1948, was established separately by the National Health Service (Scotland) Act, 1947. That there should be two separate Acts was accepted at the time almost without comment and over the years commentators on the National Health Service have paid little or no attention to the separate existence of two services operating in parallel yet retaining their quite distinctive characteristics.

My career within the National Health Service, extending over almost all of its first fifty years, was almost entirely in Scotland but included frequent opportunities to experience the NHS as it operates elsewhere in Britain. Like every clinician who has practised both north and south of the border, I was often made aware of important differences in the organisation and, even more clearly, in the ethos of the two services.

No published history has yet explained how services in the two countries came to be so different or how the histories of the creation of the two services relate to each other. One of the most often quoted of these histories was written by John Pater.¹ It was based on his personal insights, as a senior member of the Ministry of Health, into circumstances and events in England and Wales during the 1940s. Pater recognised that 'in Scotland the National Health Service has a history peculiar to itself'² of which he had no personal knowledge. His account is therefore confined to events in London.

In the official history of the National Health Service, Charles Webster does make some reference to the NHS in Scotland. However, he dismisses the separate legislation for Scotland as no more than a late modification of the National Health

¹ J. E. Pater, *The Making of the National Health Service* (London, 1981).

² Ibid. p. xi

Service Bill for England and Wales made late in March 1946 to 'permit [its] adaptation to the characteristic administrative and geographical conditions of Scotland.' He suggests that the Scottish Bill was simply an 'echo of its English counterpart'.³ Since no other historian has yet offered an alternative, Webster's assessment has been widely accepted. The purpose of this thesis is to dispute the official history and to show that the separate legislation for Scotland represented very much more than a last minute administrative expedient.

As Richard Titmuss has observed, 'when we study welfare systems we see that they reflect the dominant cultural and political characteristics of their societies.'⁴ The rapid and intense industrialisation and urbanisation of Scotland in the nineteenth century had consigned the great mass of Scotland's population to appalling living conditions and steadily deteriorating health. When the climax of Scotland's Economic Miracle passed, the decline of heavy industry threatened even these poor living standards and in the 1930s the crushing unemployment and poverty of the Depression created a social crisis experienced with equally severity only in parts of northern England.

At the beginning of the twentieth century a strong sentiment of nationalism had led to the creation of a devolved health bureaucracy in Scotland determined to take its own line, independent of Whitehall, in responding to the country's social problems. Unlike the Ministry of Health this separate bureaucracy was advised and supported in Scotland by a medical profession with a long tradition of public service. After a careful review of the deficiencies of the existing health services, in 1936 the Department of Health for Scotland published in the Cathcart Report a plan for the introduction of a freely available comprehensive health service. By the early years of the Second World War, the implementation of the plan had already begun in Scotland. That the various bodies with responsibility for health in Scotland had been able to respond urgently to the country's undeniable problems was due to a habit of co-

³ C. Webster, *The Health Services Since the War i* (London, 1988), p. 103.

⁴ B. Abel-Smith and R. Titmuss, *The Philosophy of Welfare* (London, 1987).

operation cultivated since the early years of the century – a habit that continued as the basis of the consensus that later distinguished the formation of the NHS in Scotland.

In sharp contrast, between the wars, the Ministry of Health failed to recognise the extent of the deficiencies in health care and the medical profession in England and Wales continued in its settled tradition of entrepreneurial ambition. When, in 1942, acceptance of the Beveridge Report suddenly committed government to the creation of a comprehensive state medical service, the Ministry of Health had no relevant plan of its own. No effective co-operation had been established among the health services of England and Wales at that time and agreement was difficult to reach. As its official historian has observed, in the path towards the NHS for England and Wales there was ‘a notable lack of consensus.’⁵

This thesis discusses the social conditions, political actions and medical traditions that shaped the separate development of health services in Scotland. It will be shown that in the first decades of the twentieth century the roots from which the NHS was to grow were established quite separately north and south of the border, giving rise to services with distinctive characteristics that have persisted for over fifty years.

The structure of the thesis was suggested by the speech made by the Secretary of State for Scotland when he introduced the National Health Services (Scotland) Bill for its Second Reading in the House of Commons on 10 December 1946. He informed the House that the Highlands and Islands Medical Service (HIMS) had successfully operated as a comprehensive state health service since 1913 providing ‘the necessary pointers toward having a comprehensive service in Scotland as a whole.’⁶ He also made it clear that it was the Cathcart Committee,⁷ of which he had ‘the honour and

⁵ C. Webster, *The National Health Service: A Political History* (Oxford, 1998), p. 3. Webster first commented that there had ‘been little sign of consensus’ in Webster, 1988, op. cit., p. 28. In a hostile review, D. M. Fox, in ‘Anti-intellectual History?’ *Social History of Medicine*, iii, 1990, pp.101-105, claimed that the assertion had been made with insufficient evidence. In the same issue of the journal Webster reasserted the judgement quoted here.

⁶ *Hansard*, xlxxxi, HC 10 December 1946, col. 998.

⁷ Report of the Committee on Scottish Health Services, 1939, Cmd. 5204.

privilege to be a member,'⁸ that 'with all the facts before them'⁹ and having reviewed the progress that had already been made in Scotland, had provided the basis for the Scottish Bill presented in 1946.

In Chapter One, the Highlands and Islands Medical Service is presented as an early achievement of Scotland's devolved health bureaucracy in responding to the particular social circumstances in a unique part of Scotland. As the first comprehensive and freely available medical service in Britain, the HIMS is discussed as the forerunner of - and as a potential pilot study for - the National Health Service, not only for Scotland but also for Britain. The Archives of the Royal College of Physicians of Edinburgh, provided important material including papers relating to medical services in the Highlands and Islands in 1851 (Physicians' Report), correspondence between the College and the ministers and doctors of the highlands parishes at that time, W.P Alison's works on poverty and famine in nineteenth century Scotland and the Annual Reports of the Highlands and Islands Medical Services Board. The records of the Highland parishes were studied in the archives of Highland Council in Inverness. Veronica Cecil, a direct descendant of John Coldstream,¹⁰ kindly described the background to the origins of the inquiry into medical services in the Highlands in 1851. A number of doctors and patients were interviewed during the investigation adding their own illuminating experiences of the HIMS.

The greater part of the thesis takes the Cathcart Report as the framework for a discussion of the development of Scotland's health bureaucracy, its response to the unique health and social problems of Scotland and the traditions of the medical profession in Scotland, the essential elements in the separate development of health services in Scotland.

⁸ *Hansard*, op.cit., col. 996.

⁹ *Ibid.*

¹⁰ Dr Coldstream was a close friend of Charles Darwin, a founder of the Edinburgh Medical Missionary Society and the Fellow of the Royal College of Physicians who instigated the College's inquiry into medical services in the Highlands in 1851.

The papers relating to the formation and the deliberations of the Cathcart Committee were destroyed as a fire precaution at St. Andrews House early in the Second World War. However, there are many published reports of the Scottish Board of Health, the Department of Health for Scotland and the Registrar General for Scotland that have not previously been used in this context.

Invaluable material has been found in the archives of the University of Edinburgh, the University of Glasgow, the Scottish Records Office (now the National Archive of Scotland), the Public Record Office, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow. In London, the archives of the Royal College of Physicians of London, the British Medical Association, the General Medical Council and the Royal Medical Society have also proved very helpful. I am most grateful for the generous efforts made by the archivists and staff of all these bodies on my behalf.

I am indebted to those civil servants, administrators, nurses and doctors who had taken part in the planning and establishment of the NHS in the 1940s and who agreed to be interviewed. Their evidence, recorded on tape,¹¹ has been invaluable in assessing the attitudes, circumstances and events in Scotland before and during the Second World War and at the introduction of the new service in 1948. I am particularly indebted to those former senior civil servants who had carried major responsibilities for the creation of the original structure of the NHS in Scotland and who had not previously spoken publicly of their experiences or recorded their personal judgements of events.

Ekkeharde von Keunssberg, a general practitioner in Edinburgh and the first President of the Royal College of General Practitioners, has allowed me to read his, as yet unpublished, autobiography. The papers of Sir Douglas Haddow, private secretary to the Secretary of State for Scotland during the Second World War, were kindly lent by his son. Professor James Williamson has contributed a number of valuable papers relating to the control of tuberculosis.

¹¹ The tapes are now in the Archive of the Royal College of Physicians of Edinburgh.

In setting the context for the new material presented in this thesis it has been necessary to consult and refer to a large number of secondary sources and these have been acknowledged and listed in the bibliography.

The study has been conducted with the guidance and encouragement of Dr. John Brown of the Department of History, Edinburgh University who has shown great kindness and understanding to a neophyte converting to a new discipline. Dr. Michael Barfoot, Archivist of the Lothian Health Board, and Dr. Steve Sturdy of the Science Studies Unit, University of Edinburgh have been sound sources of advice. I am also deeply grateful to Ian Milne, Librarian of the Royal College of the Physicians of Edinburgh and his staff for their constant and willing help and also to Emily Naish, Archivist of the BMA, James Beaton, Librarian of the Royal College of Physicians and Surgeons of Glasgow, Professor Michael Moss, Archivist of the University of Glasgow, Margaret Gladden of the Department of Physiology, University of Glasgow and Robert Steward, Archivist of the Highland Council. It must also be recorded that, over four years, this study has enjoyed the continuing interest and encouragement of the Senior Fellows of the Royal College of Physicians of Edinburgh.

CHAPTER ONE

THE HIGHLANDS AND ISLANDS MEDICAL SERVICE

On 12 July 1913 Parliament voted £42,000 to fund Britain's first comprehensive¹ state medical service. Within a few years the Highland and Islands Medical Service (HIMS) had gone beyond the initial purpose of its founding legislation and had earned a 'high reputation internationally and locally'² as a well-organised medical service giving 'medical care of high quality to the people.'³ On presenting the National Health Service (Scotland) Bill to the House of Commons in 1946, the Secretary of State for Scotland acknowledged the part played by the HIMS in 'carrying us forward to the health services of today'⁴ and in providing 'the necessary pointers towards...a full and comprehensive service in Scotland.'⁵

Yet this groundbreaking service has gone almost unnoticed by historians of the National Health Service (NHS). Webster gives the HIMS only one sentence;⁶ Honigsbaum is hardly more generous in less than a paragraph;⁷ Hamilton mentions it only briefly;⁸ Pater does not mention it at all.⁹ Less surprisingly perhaps, the HIMS is not included in the specialised studies by Eckstein¹⁰ and Eder.¹¹ Although the HIMS

¹ The HIMS was founded to make general practitioner services available to everyone in the Crofting Counties, within a few years it had extended its scope to include all medical services.

² *The Lancet*, i, 1950, p. 580.

³ *Ibid.*

⁴ *Hansard*, xlxxxi, HC 10 December 1946, col. 996.

⁵ *Ibid.*, col. 998.

⁶ C. Webster, *The Health Services Since the War* i (London, 1988), p. 104.

⁷ F. Honigsbaum, *Health, Happiness, and Security* (London, 1989), p. 66.

⁸ D. Hamilton, *The Healers* (Edinburgh, 1981).

⁹ J. E. Pater, *The Making of the National Health Service* (London, 1981).

¹⁰ H. Eckstein, *Pressure Group Politics* (London, 1987).

was introduced as a solution to a difficulty in the implementation of the National Insurance Act of 1911, it is not discussed by Gilbert.¹² Even the admirable social histories of twentieth century Scotland either make no mention of the HIMS (Smout,¹³ Dickson and Treble,¹⁴ Leneman,¹⁵ Checkland and Lamb,¹⁶ Devine and Finlay¹⁷) or contain only a brief notice (Harvie,¹⁸ Levitt¹⁹). Rosalind Mitchison, in her *History of Scotland*, does make passing reference to the Highlands and Islands Medical Service as 'a forerunner of the National Health Service.'²⁰ But in what sense was it a forerunner?²¹ The experience of the HIMS was certainly not marginal, relevant only to its own time and place. In retrospect it becomes clear that closer attention to its organisation and development could have corrected some of the unrealistic assumptions made in the planning of the National Health Service. Only in the 1940s was it realised that the HIMS offered 'pointers toward a full and comprehensive health service.'²² Even then not all of the pointers had been recognised.

Early in the twentieth century the Highlands and Islands had 'become something of a laboratory for administrative and legislative experiments' in Britain since 'it is in these remote districts that experimental remedies may, with

¹¹ N. Eder, *National Health Insurance and the Medical Profession in Britain* (London, 1982).

¹² B. Gilbert, *The Evolution of National Insurance in Great Britain* (London, 1966).

¹³ T. C. Smout, *A Century of the Scottish People* (London, 1986).

¹⁴ A. Dickson and J. H. Treble (eds.), *People and Society in Scotland* iii (Edinburgh, 1992).

¹⁵ L. Leneman (ed.), *Perspectives in Scottish Social History* (Aberdeen, 1988).

¹⁶ O. Checkland and M. Lamb (eds.), *Health Care as Social History: the Glasgow Case* (Aberdeen, 1982).

¹⁷ T. M. Devine and R. Finlay (eds.), *Scotland in the 20th Century* (Edinburgh, 1996).

¹⁸ C. Harvie, *No Gods and Precious Few Heroes* (Edinburgh, 1981), p. 75.

¹⁹ I. Levitt, *Poverty and Welfare in Scotland 1890-1948* (Edinburgh, 1988), p. 51.

²⁰ R. Mitchison, *A History of Scotland* (London, 1982), p. 415.

²¹ Mitchison is inaccurate in stating that the HIMS 'arose from the discovery by the Poor Law Commission that the highlands and islands were twenty years behind the rest of the country in medical provision.' Mitchison, op.cit., p. 415.

²² *Hansard*, 10 December 1946, op.cit.

comparative impunity, be tried.'²³ In 1913 the people of the West Highlands and Islands provided an ideal population for a social experiment. The population was clearly defined by geography and by demography. The crofting community also showed a very useful degree of uniformity in social conditions making it a reliable sample as an experiment in social administration.

However the HIMS was not set up as a social experiment. It was created to as an expedient to overcome difficulties in implementing the National Insurance Act in the crofting community of the Highlands and Islands. As presented in 1911 the National Insurance Bill provided for the compulsory contributory insurance of all manual workers - both men and women - between the ages of sixteen and seventy, who were employed under contract of service. It also provided for the insurance on a voluntary basis of anyone²⁴ who was wholly or mainly dependent for his livelihood on some regular occupation whose annual income did not exceed £160. Together the employee and the employer paid 7d a week (6d for women); in the case of an adult male contributor the state added a contribution of 2d; voluntary contributors were required to pay both the employee's and the employer's contributions. For each contributor to the scheme the financial benefits were to be operated by the Approved Society (Friendly Society, Trade Union or Industrial Insurance Company) of which he was a member. Those who were not members of an Approved Society - generally regarded beforehand as 'the very poorest of the poor'²⁵ - were to be insured as Deposit Contributors in an arrangement administered by the Post Office. Lloyd George's Insurance Bill was principally intended to protect the nation's workforce from the extremes of poverty during periods of unemployment but contributors to the scheme also became entitled to a medical benefit in the form of such medical attendance, treatment and medicines as would normally be provided by a general

²³ J. Day, *Public Administration in the Highlands and Islands of Scotland* (London, 1918), p. 6.

²⁴ This provision was intended to protect 'white collar' workers on low incomes.

²⁵ *Hansard*, xxxi, HC 21 November 1911, col. 921.

practitioner together with a Maternity Benefit (as a sum of money) and an ill-defined right to treatment for tuberculosis.

Those responsible for drawing up the Bill had 'realised from the beginning that there were various categories of employed people, for whom by reason of their occupation, the general conditions of the scheme would need modification.'²⁶ The population of the Highlands and Islands of Scotland made up one such category.

The Crofting Community as a Special Case

The Highlands and Islands made up a unique part of the country. Remote and almost untouched by industrialisation its population was made up principally of smallholders (crofters) and their dependent landless cottars. In 1884, an inquiry into the condition of the people²⁷ had led in 1886 to the Crofters Holdings Act which established a Crofters Commission to administer the distribution and settlement of the land on which the crofters depended for their subsistence. The 'Crofting Counties,' the area designated for this special administrative provision, included Shetland, Orkney, Caithness, Sutherland, Ross and Cromarty, Inverness and Argyll. For the purposes of the Act a crofter was defined as a 'small farmer with or without a lease, who finds in the cultivation of his holding a material portion of his occupation, earnings and sustenance and who pays rent to the proprietor,'²⁸ this definition of 'crofter' was further defined as tenants paying £30 or less per annum in rent,²⁹ although in practice few crofters had holdings carrying rents of over £6.³⁰

²⁶ W. J. Braithwaite quoted by Sir Leslie Mackenzie, *Lancet*, ii, 1928, p.105.

²⁷ *Report of the Inquiry into the Condition of the Crofters and Cottars of the Highlands and Islands of Scotland*, 1884, Cd. 3980. (Napier Report)

²⁸ *Ibid.*, p. 3.

²⁹ J. Hunter, *The Making of the Crofting Community* (Edinburgh, 1976), p. 161; J. Brown, 'Scottish and English Land Legislation,' *Scottish History Review*, xlvii, 1968, p. 72.

³⁰ Hunter, *op.cit.*

Earlier, in 1851, Sir John McNeil, the Chairman of the Board of Supervision, had estimated that, to be viable, a croft should have at least 10 acres with access to grazing.³¹ But he had to accept that there was not enough arable land available to the crofting population for this to be possible. In 1886 the land available for distribution among the crofters was still equally scarce and the Crofters Holdings Act could set the minimum size of a croft at no more than six acres. On plots of this size the crofters and their families could maintain only a bare subsistence unless supported by income from seasonal work or from contributions from the wages of family members who had found employment away from the croft. Since crofters, with their peculiar form of rural economy, made up the bulk of the population the idea of the Highlands and Islands as a special case deserving special treatment was already established in the minds of British policy makers well before the introduction of the National Insurance Bill in 1911.

Almost by definition crofters were poor. For many a weekly contribution of even a few pennies represented an unaffordable proportion of a very low cash income. In 1911 it was almost unknown for crofters to be members of Friendly Societies or subscribers to industrial insurance companies. Local contributory schemes had been tried in which a small membership fee had entitled the member and his family to the services of a general practitioner. Such Medical Associations had been introduced in the Highlands and Islands towards the end of the nineteenth century and in the most prosperous areas a few had survived, at least for a time. But in the townships and villages of the Hebrides and the west coast, Medical Associations had been formed, the initial fees paid and doctors engaged, but had then failed as members found it impossible to keep up the required cash payments. In 1911 a compulsory weekly contribution to new state insurance scheme still presented the same difficulty.

³¹ F. Gillanders, 'The West Highland Economy,' *The Transactions of the Gaelic Society of Inverness*, 1962, p. 257.

Since neither crofters nor cottars were generally members of a Friendly Society or contributors to an Industrial Insurance Company it was open to them to join the National Insurance scheme as Deposit Contributors. But as Deposit Contributors they were then at a great disadvantage. While the Approved Societies operated by collecting contributions from a very large number of contributors to create a fund from which each contributor could draw at times of need, in the Post Office scheme there was no such accumulation of a common fund. The scheme for Deposit Contributors operated on a 'dividing out' basis; the contract was not life-long but annual. If a subscriber failed to continue his contribution his right to benefits, including medical benefit, expired at the end of the current year. This anomaly was discussed in the House of Commons during the Committee stage of the National Insurance Bill in November 1911. 'The Post Office contributor has no benefit from the principle of insurance at all – absolutely none from beginning to end.'³² For many in the working population of the Highlands and Islands inclusion in the National Insurance therefore presented great difficulties. Even more were excluded from the scheme entirely. Crofters were self-employed in the cultivation of their crofts and those who increased their income by also working elsewhere rarely had formal contracts of employment.

There were others in the working population in other parts of Britain who had their own difficulties with the provisions of the National Insurance Act.³³ But in one vital circumstance the people of the Highlands and Islands were unique. As was pointed out in the House of Commons, even when 'they pay their contributions weekly they will not be able to derive any medical benefit whatever.'³⁴ The necessary local general practitioner services were not to be found.

³² Sir A. Cripps. *Hansard*, 21 November 1911, op.cit., col. 923.

³³ The problems as experienced in the Lowland farming community are illustrated by the incident of the 'Turra Coo.' A. Fenton, *The Turra Coo* (Aberdeen, 1989).

³⁴ *Hansard*, 21 November 1911, op.cit., col. 919.

For generations few doctors had been able to make a living in the Highland and Islands. Over some two hundred years the old kin based and militaristic Gaelic society of the Highlands and Islands had been dissolved and transformed.³⁵ In the process Highland society had been deprived of its middle class, those who 'held a middle station by which the highest and lowest orders were connected.'³⁶ There remained too few of the 'highest' to support and retain a medical presence in the Highlands and Islands and the 'lowest' were too poor to finance one.

Large numbers of the middle class of lesser gentry had been driven out in the process of the commercialisation of Highland properties. Clan lands had become Highland estates and clan chiefs had become landed gentlemen with estates that had to be managed on a commercial basis. In the new commercial world an estate devoted to the old ranch style economy of cattle rearing could no longer produce a profit for the owner or support the numbers of small sub-tenancies demanded by a growing population. Estates were 'improved', first in line with the modern farm practices of the Lowlands and later for sheep farming and later still for sport. At each stage larger and larger management units were needed. Small tenants were removed from the hill and moved to the coast to make a living from the sea. The leases of tenants of the middle rank (tacksmen) were not renewed or renewed at vastly inflated rents. For most tacksmen the solution was emigration; they opted to 'throw up their tacks, convert the remainder of their subject into cash' and resolving 'to try their fortunes in another country.'³⁷

³⁵ This transformation has been reviewed in the last fifteen years by a number of distinguished historians; J. Hunter, op.cit.; T. M. Devine (ed.), *Improvement and Enlightenment* (Edinburgh, 1989); J. Hunter, *The Claim of Crofting* (Edinburgh, 1991); T. M. Devine (ed.), *Scottish Emigration and Scottish Society* (Edinburgh, 1992); T. M. Devine, *Clanship to Crofters' War* (Manchester, 1994); T. M. Devine, *Exploring the Scottish Past* (Edinburgh, 1995); C. Withers, *Urban Highlanders* (East Linton, 1998); T. M. Devine (ed.), *Eighteenth Century Scotland* (East Linton, 1999).

³⁶ Samuel Johnson, *A Journey to the Western Highland of Scotland*, quoted by J. Hunter, *A Dance Called America* (Edinburgh, 1994), p. 40.

³⁷ Scotus Americanus, quoted by Hunter, 1994, op.cit.

As the middle classes of the old Gaelic Society disappeared so also did its ancient and distinctive medical profession. There had been physicians, highly skilled in the orthodox medicine of their times, in the Highlands since the fifteenth century. Many were educated at the universities of Montpellier, Paris or Leiden; others had their knowledge and skills handed down in apprenticeship style from father to son. Physicians had their place in Highland society as retainers in the households of the clan chiefs. While the physician's first duty was to the chief and his household, by the seventeenth century there was also a sizeable educated middle class, 'of education and considerable endowments,'³⁸ which provided ample opportunity for private practice.

With the disintegration of the clan system, chiefs no longer maintained households. Highland physicians were deprived of their patronage and, without patronage and without the custom of a middle class, doctors could no longer make a living in the Highlands. Although the Scottish medical schools were producing large numbers of graduates from early in the eighteenth century, until the middle of the nineteenth century very few Highland parishes had the service of a doctor with any recognisable qualifications. In that time almost nothing was spent by the parishes on the medical care even of their destitute poor.³⁹ The ordinary people could expect some medical aid from the educated men of the parish – usually the minister, occasionally the schoolmaster or the factor.⁴⁰ This amateur assistance could be reasonably competent and helpful. Many parish ministers had prepared themselves for the role of irregular medical practitioner; it was common at that time for medical

³⁸ Samuel Johnson quoted by Hunter, op. cit.

³⁹ I. Levitt and T. C. Smout, *The State of the Scottish Working Class in 1943* (Edinburgh, 1979), p. 217.

⁴⁰ Royal College of Physicians of Edinburgh, *Statement Regarding the Existing Deficiency of Medical Practitioners in the Highlands and Islands* (Edinburgh, 1852), p. 2. 'My own means have been considerably tested in the way of giving medicine to my poor practitioners – and not only medicine but food for the nourishment of the sick,' Rev. Augustus Macintyre of Kinlochbervie to Royal College of Physicians of Edinburgh, 8 April 1851(RCPE Archive)

subjects to be included in the liberal studies of any student at Scottish Universities and most educated families owned a copy of William Buchan's excellent and best selling *Domestic Medicine*. The amateur help was willingly given but was far from satisfactory as a medical service.

Medical Services before 1913

Professional medical help of a kind began to find its way to the Highlands and Islands in the first half of the nineteenth century. As communications improved and contacts with the south increased, surgeon-apothecaries began to set up in practice although few found it possible to make a living outside the main centres of population such as Inverness or Stornoway. Real improvement in general practitioner services came only in 1845 with the passage of the Poor Law (Scotland) Amendment Act. This Act⁴¹ which required parish councils to provide medical attendance to the physically or mentally ill poor conveniently failed to give a clear definition of 'poor'. Parishes, using this loophole in the Act, began to engage doctors, in theory to provide services for the poor, but in practice to serve the whole parish. This liberal interpretation of the Act was further encouraged in 1848 by the allocation to Scotland of a Medical Relief Grant of £10,000. Parishes were entitled to apply for a contribution from this fund to match whatever could be raised locally for medical services. Almost all parishes in the Highland and Islands applied. Doctors already in practice, but finding it difficult to make ends meet, were offered additional emoluments as an inducement to stay. A guaranteed subsidy was offered to attract new doctors to set up in parishes that had previously been unable to support a medical practice. Since the graduates of Scotland's eight medical schools were, at

⁴¹ The Act was more advanced than that passed for England and Wales in 1834 which merely gave magistrates the power to order medical relief in cases of sudden sickness.

that time, having difficulty in finding employment in the United Kingdom there was brisk competition for all the positions on offer.

While the terms of employment were attractive in theory, in practice they proved to be unsatisfactory. Doctors found themselves subject to an uncomfortable form of parochial patronage. Appointments were often made for political or social reasons which had little to do with the medical skills of the doctor or the priorities of care in the parish.⁴² The stipend offered usually bore little or no relation to the number of registered paupers for whom the parish was legally responsible. The amount offered usually reflected the strength of local will to have a doctor resident in the parish and the stipend received by the doctor could vary from £25 in a parish with 240 registered paupers to £70 in a parish with one. In a few parishes the doctor might also received a subsidy from the local landowner and doctors were allowed to attend private patients. But fees were seldom paid⁴³ and for almost all doctors, payment received for parochial duties made up by far the greater and essential part of income. In the second half of the nineteenth century, new Public Health legislation increased the scope of these parochial duties. Under the Vaccination (Scotland Act) of 1863 parish medical officers could become vaccination officers. The Public Health (Scotland) Act of 1867 and the Local Government (Scotland) Act of 1894 added Public Health responsibilities. The Board of Supervision encouraged parish authorities to extend medical care to their aged residents whether or not they were on the paupers roll;⁴⁴ at the beginning of the twentieth century the responsibilities accepted by parish medical officers increased further following the Old Age Pension Act of 1908 and the establishment of the School Medical Service.⁴⁵ In recognition of

⁴² S. Blackden, 'From Physicians' Enquiry to Dewar Report,' *Proceedings of the Royal College of Physicians of Edinburgh*, xxviii, 1998, p. 63.

⁴³ *Ibid.*, p. 60.

⁴⁴ T. Ferguson, *Scottish Social Welfare 1864-1914* (Edinburgh, 1958), p. 362.

⁴⁵ Attendance on the elderly was voluntary but expected. Services in the Local Lunacy Service were also unpaid. Appointments to the Factory Medical Service and the Post Office Medical Service were financed centrally.

these expanding local services the Medical Relief Grant had been increased to £20,000 in 1882. But even with this additional support parishes could not afford to employ the number of doctors required for the work of the parish and without a guarantee of parish employment new doctors could not be attracted to the Highlands. For those already employed by the parishes there were few inducements to stay. Incomes often barely covered expenses. Paupers had to be attended day and night and travel was difficult, costly, and very often over long distances.⁴⁶ On average, from the 1850s, each doctor's practice extended over some 400 square miles and the average number of potential patients was approximately 5,250.⁴⁷ Medicines had to be provided by the doctor from his own funds. Above all, medical officers were appointed at the pleasure of the parochial boards and there was no security of tenure.

In an inquiry carried out in 1851 the Royal College of Physicians of Edinburgh had found that of the 155 parishes surveyed in Highland and Islands,⁴⁸ in only 60 did the people feel that they had any useful access to a doctor.⁴⁹ There were at that time only 84 medical graduates⁵⁰ in general practice in the 14,000 square miles of the Highlands and Islands. By 1883, when the Napier Commission⁵¹ investigated the living conditions of the people of the region, that number had

⁴⁶ Some parishes were very large indeed. The parish of Gairloch 'extends about 40 miles in length and is nearly 30 miles in extreme breadth...It has about 90 miles of sea coast.' *Gazetteer of Scotland* i (Glasgow, 1841) p. 595.

⁴⁷ Calculated from the total population and the total number of doctors in residence in the region.

⁴⁸ The area later recognised as the Crofting Counties was made up of 170 parishes. Replies were received from 155; 'the parishes not reporting are chiefly in districts where the supply of medical aid is sufficient.'

⁴⁹ *Statement Regarding the Existing Deficiency of Medical Practitioners in the Highlands and Islands* was issued as a pamphlet by the Royal College of Physicians of Edinburgh in 1852. The manuscript on which the pamphlet was based is held in the College Archive (Physician's Report).

⁵⁰ From the Medical Register it has been estimated that the total number of qualified practitioners in the Highland and Islands at that time was 84. Blackden, *op.cit.*, p. 57.

⁵¹ *Report of the Inquiry into the Condition of the Crofters and Cottars of the Highlands and Islands of Scotland* (Napier Report), *op.cit.*

increased only to 103 medical graduates serving 121 of the 170 the parishes in the area later designated as the Crofting Counties. It was this persisting scarcity of doctors in the Highland and Island that led Cathcart Wason to protest, during the Committee stage of the National Insurance Bill, that Contributors in the Highland and Islands would be unable to benefit from the NHI scheme 'simply because of the impossibility of getting medical officers.'⁵²

While the British Medical Association (BMA) in London was in very public and acrimonious dispute with the Treasury as it campaigned to secure the financial position of its more prosperous general practitioners in the south⁵³ the problem for general practitioners in the Highlands and Islands was being overlooked. As the *Edinburgh Medical Journal* explained:

In all the criticism which has been showered on the National Insurance Bill we have not observed any dealing with the exceptional position of the medical men in the Highlands and Islands of Scotland. It may be that those who are familiar with the conditions of practice in those remote districts recognise that no feasible amendments of the proposed Act would really touch the question. There are districts where no capitation grant which, even in his most conciliatory mood the Chancellor could agree to, would keep body and soul together and the smallest wage limit which has been suggested would have no terrors for the ordinary crofter.⁵⁴ He has no employer and his employees are his own family. The whole contribution, then, would fall directly on him and he has no sevenpences to spare. If there ever was a case for exceptional treatment the Highlands provide it. The districts are enormous, the population very thin and very poor, and means of communication are few. The present conditions are terribly hard on those members of the profession who do their best in difficult circumstances. When conditions are exceptional, remedies must be exceptional too.⁵⁵

⁵² *Hansard*, xxx, HC 1 November 1911, col. 919.

⁵³ When the National Insurance Bill was introduced in 4 May 1911, it proposed that provision should be made for those earning less than £160 per annum. The BMA, afraid of mass defection of patients from the private practices of the more prosperous members, proposed at a meeting on 31 May 1911, that the service should be limited to those earning less than £140 per annum.

⁵⁴ While the proposed wage limit was £140, a crofter might have a disposable income £26. (Blackden, *op.cit.*, p. 213)

⁵⁵ Editorial, 'The Highland Doctors,' *Edinburgh Medical Journal*, vii, 1911, p. 100.

On 11 July 1912 the Chancellor of the Exchequer set up a committee to consider 'how far the provision of medical attention in districts situated in the Highlands and Islands of Scotland is inadequate and to advise on the best method of securing a satisfactory medical service therein, regard being had to the duties and responsibilities of the several public authorities operating in such districts.'⁵⁶ The Committee (Dewer Committee), under the chairmanship of Sir John Dewer, the MP for Inverness, was made up of people with personal knowledge and experience of conditions in the Highlands.⁵⁷ Of the nine members, three were doctors including Leslie Mackenzie, who had been largely responsible for the investigations of the Royal Commission on Physical Training in 1903, and John McVail, who had provided much of the medical evidence for the Report of the Royal Commission on the Poor Law of 1909. In the absence of definite indication in the remit as to the exact area in which the enquiry was to be carried out, the Committee chose to confine their enquiry to the area already designated in the Crofters Holding Act as the Crofting Counties.

As evidence of the inadequacy of medical services the Dewer Committee quoted the large number of uncertified deaths in the Highlands and Islands. In many parishes the proportion was over 40% and in one parish it reached 80%.⁵⁸ It was considered that 'the evidence was quite conclusive that the high percentage of uncertified deaths is due to lack of medical attendance, and that no medical service

⁵⁶ *Report of the Highlands and Islands Medical Service Committee* (Dewer Report), 1912, Cd. 6559.

⁵⁷ The Committee members were Sir John Dewer, MP for Inverness; The Marchioness of Tullibardine, J.C. Grierson, Convenor of the County of Shetland; A. Lindsay, Convenor of the County of Sutherland; Dr. Leslie Mackenzie, Medical Member, Local Government Board for Scotland; Dr. J. McVail, Deputy Chairman, Scottish Insurance Commission; Dr. A. Miller, Medical Officer for the Parish of Kilmallie; C. Orrocks, Chamberlain of the Lews; J. Robertson, Senior Chief Inspector of Schools for Scotland.

⁵⁸ Dewer Report, p. 17.

can be regarded as adequate where such neglect still obtains.’⁵⁹ The Dewar Committee’s overall conclusion was that ‘on account of the sparseness of the population in some districts, and its irregular distribution in others, the configuration of the country, and the climatic conditions, medical attendance is uncertain for the people, exceptionally onerous or even hazardous for the doctor, and generally inadequate.’⁶⁰

In 1912, the problem was getting worse for a variety of reasons. After the short period of improvement brought about by the Poor Law (Scotland) Amendment Act of 1845, general practice in the Highland and Islands had become increasingly unattractive.⁶¹ The Dewar Committee found that the number of doctors in the Crofting Counties had not increased in the previous thirty years. In the last decades of the nineteenth century the cost of medical services had become a more and more pressing problem for the parishes. The annual contribution to Scotland’s Medical Relief Fund was still being granted but increasingly its resources were being diverted to improve the appalling conditions in the cities. The subsidy to support services in rural parishes was being correspondingly diminished. Faced by a decreasing income and the increasing expenditure demanded by new mandatory public health measures, ratepayers in the Highlands and Islands were becoming less willing to subsidise the treatment of patients who were not the registered paupers for whom the parish was legally responsible. Parishes could afford fewer rather than more doctors. Parish funds could certainly not provide the subsidies that would be required to support the number of doctors necessary to ensure the provision of the medical benefit of the NHI Scheme to the whole working population of the Crofting Counties.

The most radical solution proposed to the Dewar Committee was from the doctors themselves. Among the doctors practising in the Highlands there was general

⁵⁹ Ibid., p. 18.

⁶⁰ Ibid., p. 13.

⁶¹ Blackenden, *op.cit.*, p 58.

support for the view that 'the present moment is ripe for the inauguration of a complete State medical service.... Such a scheme is a coming event all over the country in the near future.... The starting of such a service in the Highlands could be done with less opposition and much less friction than in the more densely populated parts of the country.... Both doctors and the public would favour such a form of medical service.'⁶²

However, the Dewar Committee looked to less radical and more immediately practicable measures to repair the existing deficiencies. In its view the inadequacy of medical provision was not due to an absolute shortage in the total number of general practitioners, though there were obviously too few in some districts.⁶³ In retrospect it can be seen that this was a reasonable judgement. The Census of 1911 shows that the Highlands, with 6 % of Scotland's population, had 5.6% of Scotland's doctors.⁶⁴ However the geography of the region made it impossible for this number of doctors to have adequate access to a very scattered population. In spite of the obvious difficulties in practising medicine in the Highlands, there had been many eager recruits from Scotland's eight medical schools. However the turnover had been rapid. In the more remote parishes in particular, doctors often remained perhaps only for a year before moving on. The Dewar Commission took a somewhat unsympathetic view of those who chose to remain. In its judgement the majority of the doctors seemed to fall into

two classes - a) Young men recently out of college who make the appointment merely a stepping stone to something better, who remain only a year or two and b) older men, who after perhaps a chequered career, fall back on such places as a last resort and harbour of refuge. While to the capable man, who, from inclination or perhaps the force of circumstances, elects to spend his life in these regions, the most hopeful outlook before him is to die in harness, in case he dies of

⁶² Dewar Report. Minutes of Evidence, 1913, Cmd. 6920, Minute 19,718.

⁶³ Dewar Report, Cmd. 6559, op.cit. p. 13.

⁶⁴ M.W. Dupree and A. Crowther, 'A Profile of the Medical Profession in Scotland', *Bulletin of the History of Medicine*, lxxv, 1991, p. 209.

starvation when old age and decrepitude render him incapable of work.⁶⁵

In the view of the Dewar Committee, the failure to recruit adequate numbers of good competent and reliable doctors could be attributed to the 'defective means of locomotion and communication and to the variety of conditions vitally affecting the welfare of the profession, which conditions in turn are calculated to discourage the average practitioner in the exercise of his profession and to prevent him from rendering service commensurate with the need of the people.'⁶⁶ No doctor in the Highlands could easily afford to buy a car or a motor boat although in many cases he required both.⁶⁷ There was no reliable telephone service. Doctors' houses were unsatisfactory 'both as regard accommodation and situation.'⁶⁸ Doctors had no security of tenure; 'the Parish Council has absolute power of dismissal and cases were cited where the Council appears to have acted harshly.'⁶⁹ 'That the average income of the medical profession was low those who know the Highlands and Islands intimately were well aware, but we were not prepared to hear that so many medical men were eking out a living, and some of them trying to educate a family, on incomes well below the limit of income tax.'⁷⁰ Incomes were so low that the average doctor could not take a holiday, or take advantage of post-graduate courses because the cost of a locum was beyond his means. In his evidence to the Commission the Statistical Officer at Register House, Dr. J.C. Dunlop, suggested that general practitioners should have a guaranteed net income of £400, with housing and travelling expenses, to bring him in line with medical officers in the Colonial medical services ('It is as great banishment to go to some of these places as to go to

⁶⁵ Dewar Report, p. 35.

⁶⁶ Ibid., p. 13.

⁶⁷ It had long been the practice of many doctors to hire a horse, a horse and buggy or a boat only when required.

⁶⁸ Ibid., p. 15.

⁶⁹ Ibid., p. 14.

⁷⁰ Ibid.

Borneo. Being stranded at Barra for the winter, or at Coll or Tiree, is not very tempting to a man with ambition.’⁷¹) While Dr. Dunlop believed it would be difficult to get a self-respecting man for less than £400 there were many parishes in the Highlands and Islands in which the doctor earned less than £50 or £70 a year. ‘In order to subsist he must continue in harness long after he is fit to discharge his duties efficiently. Some form of superannuation scheme seems worthy of consideration.’⁷²

Shortage of doctors was not the only problem. The Dewar Committee was impressed by the volume of evidence, both from doctors and members of the public, that ‘no matter affecting the welfare of the people of the Highlands and Islands is more urgent than the provision of an adequate supply of trained nursing.’⁷³ However the total number of nurses at that time was quite inadequate and the efficiency of the nursing service suffered from an almost complete lack of organisation. In the second half of the nineteenth century the formation of Nursing Associations had become a favourite charitable enterprise for the wives of landowners in the Highlands. For an annual subscription of between 2 shillings and 10 shillings members were entitled to nursing services and for non-members the nurse’s services were available at a small fee. The nurses first recruited by the Associations were Cottage Nurses with at least six months experience in a recognised hospital or Maternity Nurses, usually widows who had received three months training. After 1897, nurses for these Associations were usually found through the agency of Queen Victoria’s Jubilee Institute of District Nursing, set up by the Queen Victoria’s Jubilee Fund. The Institute required higher standards of training; their nurses were only accepted as qualified after three years hospital experience and a further period of training in the care of the sick poor in their own homes. The cost to the local associations for the employment of a Queen’s Jubilee nurse varied from £80 to £90 from which the nurse received a

⁷¹ Ibid., p. 17.

⁷² Ibid., p. 14.

⁷³ Ibid., p. 20.

standard annual salary of £35. In some parishes a house was provided; otherwise the nurse was allowed 10s a week for lodgings. A bicycle was provided for transport. Special effort was made to find nurses for the parishes rarely visited by a doctor. In these remote parishes they served an important educational function, teaching basic sanitation and nutrition, as well as performing the practical nursing duties of caring for the sick and injured. But in 1912, few parishes could afford a nurse trained to this standard.

The Dewar Committee also found that the existing general hospital provision was quite inadequate even when used to its full capacity, which usually it was not. In spite of the known inadequacies in medical and nursing services most treatment, whether of illness or injury, had to be managed at home. In 1850 the only hospitals serving the crofting counties had been at Kirkwall and at Inverness, both at the periphery of the area and accessible to only a very few of its people. Later in the century, the cottage hospital movement had established sixteen small hospitals across the Crofting Counties, each with an average of eight beds. Two larger hospitals of 22 beds had been opened at Oban and at Lerwick, and at Inverness (itself outside the Crofting Counties) the Northern Infirmary of 68 beds provided services for the Crofting Counties of the north-east. But travel to hospital was difficult and patients were reluctant to leave home for treatment of uncertain benefit in an alien environment. As a result the few hospital beds available in the Highlands were very often left empty. Only the most desperately ill were willing to travel. In 1912 patients from the west coast requiring modern hospital treatment had to endure the sea journey to Greenock or Glasgow Royal Infirmaries and patients from the Orkneys and Shetland had the long journey to Aberdeen or Edinburgh. The majority in need of hospital treatment opted to remain in their own part of the world in spite of its lack of modern hospital services. The Dewar Committee's answer to this problem was

that the local hospitals should be improved.⁷⁴ More cottage hospitals should be built 'a) to bring near to the doctor a distant case requiring frequent visits. b) to provide for the removal of patients from conditions that render medical treatment largely futile. c) to reduce the cost and danger of travel entailed in removal from outlying parts to the existing hospitals. d) to provide a home for the district nurse and a local dispensary for the doctor.'⁷⁵ It was also suggested that there should be more provision for the treatment of tuberculosis.

The Dewar Committee did not review local authority services in spite of their obvious relevance to the distribution of local financial resources on health. Until the end of the nineteenth century the Highlands and Islands were almost without public health services. There were no sanitary programmes of any kind before 1867.⁷⁶ Then under the Public Health (Scotland) Act of 1867 the parochial boards across Scotland became the responsible sanitary authorities with powers for the prevention and mitigation of infectious disease by the provision of hospitals and by improving sanitation.⁷⁷ In the Highlands and Islands the Act remained in these respects almost a dead letter.⁷⁸ In 1885 the Inspector for the North Highland District complained that 'The Public Health Act, passed eighteen years ago, can hardly be said to be in operation except in a few places.'⁷⁹ This inspector attributed the lack of public health provision to apathy. But to the Local Authorities, the installation of systems of

⁷⁴ This recommendation which would have continued the dispersal of hospital beds in small local units was rejected by the Board of the HIMS.

⁷⁵ Dewar Report, p. 28.

⁷⁶ Inverness improved sanitary conditions under a local Act of 1847 but administratively the town of Inverness was not part of the Crofting Counties.

⁷⁷ The parochial boards were also empowered to provide recreation grounds, public conveniences, mortuaries, and to prevent the sale of unwholesome food.

⁷⁸ Day, *op.cit.*, p. 291.

⁷⁹ *Ibid.* The inspector suggested that 'the poisons arising from so many forms of pollution, within and without the houses are counteracted by the constant burning of the open fire burning in the centre of the houses and by the abundance of mountain and sea air which is admitted by the open and ill-fitting doors. It is also possible that the dense clouds of peat smoke in which the people continually live may have some salutary antiseptic effect.'

drainage, sewage and water supply, when there seemed to be no pressing need, was regarded as an unjustifiable expense. The demolition of substandard housing, as required by the Act, threatened to become an impossible burden on the local rates by increasing the numbers of the homeless destitute dependent on the Poor Law. Also there was little point in building isolation hospitals that would inevitably be remote and inaccessible to the majority of the population and would therefore be little used. The failure of Public Health legislation in the Highlands and Islands was explained by the Poor Law Commission in 1909:

1. The parish was much too small for public health administration.
2. The parochial board had to combine Poor Law administration with Public Health administration, and the two were incompatible.
3. The expense of officers was too great for the local funds available.
4. The interests of the individual members of the parochial boards tended always to conflict with the duties required of them as a local authority for public health.⁸⁰

By 1912 Government legislation had made no special concession to the problems of the medical services in the area in spite of the fact that it had been recognised in the Crofters Act of 1886 as so idiosyncratic as to require special administration. The Old Age Pensions Act of 1908 had helped to maintain the elderly but the medical care of increasing numbers of old people made almost impossible demands on the available services. The Education (Scotland) Act of 1908 also caused difficulties by introducing a school medical service. A Royal Commission⁸¹ had been appointed in 1902 to 'enquire into the opportunities for physical training now obtainable in state-aided schools and the other educational institutions of Scotland; and to suggest means by which such training may be made to conduce to the welfare of the pupils.' Investigations were carried out for the Commission in Edinburgh by Dr. Leslie Mackenzie and in Aberdeen by Professor Matthew Hay. The

⁸⁰ *Report of the Poor Law (Scotland) Commission*, vii, 1909, Cd. 4922, p. 182.

⁸¹ *Report of the Royal Commission on Physical Training (Scotland)*, 1903, Cd.1507.

Commissioners were appalled by the obviously poor physical state of the pupils in these urban populations and deplored the absence of any medical inspection or medical help.⁸² Government set up an Interdepartmental Committee to study the problem further. It concluded that the causes of the poor physique and medical problems of the young people of Scotland were:

1. Increasing urbanisation of the people had brought with it overcrowding.
2. The pollution of the atmosphere with the lack of sunlight that it produced, together with the absence of fresh air, was a potent cause.
3. There was insufficient inspection of workplaces. The Factory Act of 1901 had not been fully implemented.
4. The drinking habits of the women had deleterious effects on their children and were a most potent and deadly agent of physical deterioration.
5. The depletion of rural areas.
6. The tendency of the better stocks to breed less.
7. The excessive use of tea and white bread.⁸³

These were not the problems of the Highlands and Islands. Nevertheless the medical provisions of the Education (Scotland) Act of 1908, devised to meet these problems, applied to the Highlands and Islands as much as to the cities and placed another seemingly unnecessary burden on the finances of the parishes. The Act also added to the many duties of the few medical officers to no great effect. The medical problems discovered in the pupils at the school medical inspections required by the Act could be duly reported to the parents but in most cases the general practitioner services that might have remedied them were not available. Although the Poor Law Scotland (Amendment) Act of 1845 had made it possible for the parishes to divert funds to limited improvement in the general practitioner services, government legislation on public health since the middle of the nineteenth century had increased the obligations

⁸² Ibid.

⁸³ *Report of the Inter-Departmental Committee on Physical Deterioration*, 1904, Cd. 2175.

of the parishes leaving no financial resources to continue the improvement or even maintain the improvement in medical primary care begun in 1845.

In December 1913, the Dewar Committee found that the medical services in the Highland and Islands, far from being adequate for a new role in the National Health Insurance scheme, were very near to collapse. 'It is clear that having regard to the economic conditions that prevail in the Highlands and Islands, the extent to which the services are at present subscribed from the Imperial Funds is quite inadequate, and that local resources are, in many parishes, well-nigh if not wholly, exhausted, any ameliorisation of the existing medical service cannot be achieved without a further and more substantial subsidy.'⁸⁴ In an Appendix the Report included a detailed *Scheme for the Administrative Consolidation of Medical Services*⁸⁵ prepared by Dr. Leslie Mackenzie. Only six months later McKinnon Wood, the Secretary for Scotland, announced in the House of Commons

that it is expedient to make provision for improving Medical Services in the Highlands and Islands of Scotland and for other purposes connected therewith and to authorise for these purposes the payment out of moneys to be provided by Parliament of a) a Special Grant to be called the Highlands and Islands (Medical Service) Grant and b) the salaries or remunerations of the secretary and of the officers of a Board to be called the Highland and Islands Medical Board and of any expenses incurred by the Board in the execution of their duties.⁸⁶

The Highlands and Islands Medical Service

The Highland and Islands Medical (Medical Services) Board appointed in 1913 was made up of eight members, six of whom were doctors.⁸⁷ The Board brought together

⁸⁴ Dewar Report, p. 40.

⁸⁵ Ibid., p. 43. McKenzie's plan was followed closely in the formation of the HIMS.

⁸⁶ *Hansard*, lv, HC 12 July 1913, col. 1816.

⁸⁷ Sir John Dewar, Bart., MP; Lady Susan Gilmour; Sir Donald MacAlister, Principal of Glasgow University, President of the General Medical Council; Dr. Leslie Mackenzie, Medical Member of the Local Government Board for Scotland; Dr. John Macpherson, Senior Medical Commissioner in Lunacy for Scotland; Dr. John

members with personal knowledge and understanding of the way of life in the Highlands and Islands and first hand experience in the administration of contemporary medical services. Two of the members had already made important contributions to the reform of medical services and within a few years two were to make their own further very important contributions. Leslie Mackenzie, who had devised the scheme on which the new service was to be based, had been a principal author of the *Report of the Royal Commission on Physical Training on Physical Training*⁸⁸ in 1903 and had played an important part in introducing the School Medical Service,⁸⁹ in the improvement of maternity services, in the management of tuberculosis, and to improvement in housing for miners. John McVail had assisted Beatrice Webb in preparing the Minority Report of the Royal Commission on the Poor Laws and Relief of Distress in 1909.⁹⁰ Sir Donald MacAlister and Dr Norman Walker were later to be responsible for influential reports on the future of medical services in Scotland.⁹¹ Sir John Dewar, who now chaired the Highland and Islands Medical Board, had chaired the Committee that had recommended its creation.

The Board agreed to adopt Leslie Mackenzie's *Suggested Scheme for the Administrative Consolidation of Medical Service* as the basis for the new service. The area to be served was defined by the Secretary for Scotland in the House of Commons in July 1913. The Dewar Commission had recommended a service for the Highlands and Islands but as the Minister explained 'there is no statutory definition of the Highlands and Islands but there is a definition of the Crofting Counties.'⁹² The geographic limits of the area to be served were therefore set to coincide with

McVail, Deputy Chairman of the Scottish Insurance Commission; Dr. J.L. Robertson, Senior Chief Inspector of Schools in Scotland; Dr. Norman Walker, BMA Representative for Scotland on the General Medical Council.

⁸⁸ *Royal Commission on Physical Training (Scotland)*, 1903, op.cit.

⁸⁹ G. McLachlan (ed.), *Improving the Common Weal* (Edinburgh, 1987), p. 37.

⁹⁰ *Ibid.*, p. 43.

⁹¹ *A Scheme of Medical Services for Scotland* (MacAlister Report), 1920, Cmd.1039; *Report on Hospital Services* (Walker Report), 1933; NAS DH 8/1101.

⁹² *Hansard*, 12 July 1913, op.cit., col.1817.

those of the special administrative area designated as the Crofting Counties in the Crofters Holding (Scotland) Act of 1886. The new Board therefore became responsible for the provision of medical care for some 320,000 people scattered over 14,000 square miles of difficult country.⁹³ The annual Highland and Islands (Medical Service) Grant of £42,000⁹⁴ to support the new services was equivalent to one shilling and sixpence for each member of the population.

The primary objective of the HIMS was to provide general practitioner services for every member of the community. The Board found an imaginative way in which to use limited central funding to bring together a population in need of medical services, but unable to pay for them, and a medical profession eager for employment, but unable to make employment in the Highlands and Islands financially worthwhile. Payment of general practitioners by capitation fee, the system recently adopted for the NHI scheme, was seen as inappropriate; it would operate to the unfair advantage of doctors in the more populous areas who had easy access to comparatively large numbers of patients without heavy expenditure on travel. Payment by salary would have been difficult to adjust to reflect the unequal demands of very different practices and, for some doctors, would act as a disincentive to effort and initiative, especially in caring for their most remote patients. The system adopted recognised that the chief difficulty for doctors in the Highlands and Islands was the very high level of practice expenses. Travel to visit patients at home was expensive; it was also time consuming, restricting the time available for other paid work. Medicines were provided free as an expense on the practice. Even practice accommodation that was less than adequate was always costly.

⁹³ The Registrar General, who counted heads per acre to the nearest whole head, demonstrated that in 1900 the Highlands were not inhabited at all. M. Crosfil, 'The Highlands and Islands Medical Service,' *Vesalius*, ii, 1996, p. 120.

⁹⁴ 'The grant of £10,000 in aid of Mileage and other Special Charges connected with attendance on insured person is included in the annual grant in aid.' *Annual Report of the Highlands and Islands Medical Service Board*, 1915, Cmd.8246, p. 5.

In the scheme adopted by the Board, Treasury funds were used to subsidise practise expenses rather than to increase directly the doctor's income. The Board provided a grant to the practice that was calculated to reflect practice expenses, particularly the cost of travel.⁹⁵ It also made provision either for the improvement of the houses already occupied by doctors or to build new ones. In calculating the grant for each practice care was taken to ensure that the doctor's income would not fall below a reasonable minimum.⁹⁶ In return doctors were required to 'visit systematically those requiring medical attention, including Poor Law and insured persons, and also to undertake such Public Health duties as may be required.'⁹⁷ For patients not insured or entitled to treatment under the Poor Law, doctors were allowed to charge fees of 5s for a first visit and 2s 6d for any subsequent visit; the fee for midwifery was set at £1, although, based on previous experience in the region, there was little confidence that fees would be paid. The Highlands and Islands Medical Board also undertook to refund 70% of all approved expenditure of the District Nursing Associations⁹⁸ and to make additional grants to provide appropriate houses for the nurses. Grants were also planned to meet the cost (almost entirely the cost of travel) of specialist services in Aberdeen, Glasgow or Edinburgh.

The full implementation of these plans was interrupted by the outbreak of war in 1914. Doctors were recruited in 1913 but many soon left to join the armed forces. Only three houses for doctors and nine for nurses were completed before the war at a total cost of £5,730. In each of the war years the grant of £42,000 was underspent and by 1919 the Highlands and Islands Medical Service funds had accumulated to £57,000.

⁹⁵ The doctor was assisted in to providing his own motor car, motor boat, or whatever means of conveyance was appropriate.

⁹⁶ The minimum recommended in 1913 was £300 per annum. Dewar Report, p. 42.

⁹⁷ Ibid., Appendix III.

⁹⁸ Including nurses salaries.

In August 1919 the administration of the service was taken over by the newly created Scottish Health Board and the Highlands and Islands (Medical Services) Board was disbanded. Arrangements were made to allow practitioners to attend refresher courses. Dr. A Shearer, given early demobilisation from the army specifically for the purpose, was employed full-time by the HIMS Fund on a salary of £500 per annum to act as a rotating locum.⁹⁹ A scheme to provide suitable houses for doctors in the new service had been drawn up in 1916 but abandoned during the war. By 1919 the building costs, particularly on the Islands had increased by as much as three times.¹⁰⁰ Nevertheless, in 1920 the Scottish Health Board architects produced plans for suitable houses for doctors at a cost that the Board estimated that it could afford.¹⁰¹ The chief disincentives to practice in the Highlands identified in the Dewar Report were being quickly removed. The HIMS offered secure employment by central government, a small but secure income, a decent house, periods of leave and subsidised practice expenses. These terms of employment proved attractive to doctors being released from military service. The number of doctors employed in the Crofting Counties quickly increased to 155, many of them young men with excellent training and experience, and by 1924 the Scottish Board of Health was satisfied that the deficiencies in the general practitioner services in the Crofting Counties had been largely remedied.¹⁰² General practitioners were available even in the most inaccessible mainland districts and the most remote islands and it seemed that there were no remaining barriers which might prevent even the poorest from obtaining medical assistance. In 1929, when responsibility for the HIMS was transferred to the Department of Health for Scotland, general practice services were considered to be so satisfactory that they could be allowed to 'continue without

⁹⁹ NAS HH/65/1

¹⁰⁰ *First Annual Report of the Scottish Board of Health*, 1919, Cmd. 825, p. 79.

¹⁰¹ The estimated cost of each house was £746. NAS HH 65/24; NAS HH/52/1.

¹⁰² *Annual Report of the Scottish Board of Health*, 1924, Cmd. 2156.

material alteration.’¹⁰³ There were then over 160 doctors employed in 150 practices; incomes and housing arrangements had been accepted as adequate; the HIMS locum scheme had allowed up to 40 general practitioners to enjoy periods of leave each year and attendance at refresher courses was being actively encouraged by the Board. Recruitment of doctors into the Highlands and Islands was no longer a problem.

The Effects of the HIMS

As statistical evidence of improvement in general practitioner services, the *Annual Reports of the Department of Health* showed that in 1936, on average, each general practitioner had a list of some 1,900 patients, a doctor patient ratio that compared very favourably with that prevailing in the rest of the United Kingdom. In the past the high number of uncertified deaths had been taken as an index of the inadequacy of the general practitioner service. In 1911 the proportion of deaths going uncertified in the Crofting Counties had been 10.5 %; by 1931-33 this had been reduced to 4.5%. The first full review of the HIMS was included in the Cathcart Report¹⁰⁴ in 1936. Cathcart concluded that

this Service has revolutionised medical provision in the Highlands and Islands. It is now reasonably adequate in the sense that for all districts the services of a doctor are available on reasonable terms. Our witnesses informed us also that the Highlands and Islands were now attracting medical men of a quality superior to the bulk of practitioners who found their way to the Highlands before this service was instituted.¹⁰⁵

General practice owed much of its success to the improvement in domiciliary nursing services. As a witness before the Dewar Committee in 1912, Lord Lovat, Convenor of Inverness County Council,¹⁰⁶ had predicted that the medical salvation of the

¹⁰³ Ibid.

¹⁰⁴ *Report of the Committee on Scottish Health Services* (Cathcart Report), 1936, Cmd. 5204.

¹⁰⁵ Ibid., p. 225.

¹⁰⁶ Lord Lovat was also the owner of a Highland estate of 181,800 acres.

Highlands would lie in the provision and organising of nursing services.¹⁰⁷ This proved to be the case. The end of the war released large numbers of nurses from wartime service and the number of fully trained Queen's nurses employed in the Crofting Counties leapt to 123. Most parishes were soon able to have a resident nurse. Suitable houses were built, usually with small hospices of two or more beds attached.¹⁰⁸ The introduction of an automated telephone service in the West Highlands made them more readily available to their patients - although they had to rely on bicycles as their only means of transport. By 1929, seventy-three District Nursing Associations were being subsidised to employ a total of 175 nurses. Their living accommodation had been further improved and pushbikes were being replaced by motor bikes. When the Cathcart Committee reported in 1936, the number of fully qualified nurses employed in the Crofting Counties had risen to 200. As predicted by Lord Lovat, the employment of district nurses had proved to be crucial. In 1936 the Cathcart Report commented:

The combination of doctor and nurse is extraordinarily impressive. Many of the doctors say that practice in their areas would be impossible without the services of the nurses, and everywhere we are told that co-operation between doctor and nurse leaves nothing to be desired. The nurse is in a position to establish intimate contact with the people and so help in detecting illnesses at an early stage. She attends at the periodic school medical examinations and does what follow up may be arranged. In some areas the nurse also visits the schools every month to inspect the children. Not the least part of the value of the nurse lies in her work in health education. It appeared to us that she is at present the main agency for educating the people in hygiene....We are told by most witnesses that the people were improving in personal and household hygiene and most of the doctors attribute this improvement largely to the nurse.¹⁰⁹

¹⁰⁷ Dewar Report, p. 24.

¹⁰⁸ As planned by the Scottish Health Board a nurse's house cost £228, a house with a small hospice of two beds £390 and with a larger hospice £750. NAS HH/65/24; NAS HH/65/25.

¹⁰⁹ Cathcart Report, p. 228.

With their contribution general practitioner services had become much more effective. A parish minister, the Rev. John MacLeod had described the problems in treating patients at home as they were in 1850:

From day to day we Clergymen of the Highlands see what appears at the outset but simple ailments, assuming by neglect, inattention and unskilful treatment, aggravated to form dangerous and it may be fatal disease. In case of childbirth the poor females of the country are subjected to the most ignorant treatment, left generally on female attendants of their own class who have rashly assumed a calling in the nature of which they have never perhaps had one hour's instruction.¹¹⁰

The nursing services supported by the HIMS more than remedied these deficiencies adding greatly to the effectiveness of general practice. Without the support of efficient nursing services even a 50% increase in the number of doctors would have been achieved very little and, in 1929, the Department of Health for Scotland would not have found that the population of the Crofting Community was being adequately served some by 165 doctors.¹¹¹

Extending the Service

Satisfied that the deficiencies in general practice had been met, in 1929 the HIMS turned attention to hospital services, introducing a new regional policy for the Crofting Counties. Cottage hospitals, small and poorly equipped, had been randomly dispersed across the counties with each parish ambitious to have its own small complement of hospital beds. The Dewar Committee had recommended that reliance on local small cottage hospitals should continue and their number be increased.¹¹² This policy was reversed almost at once by the HIMS Board which decided that without centralisation it would be neither practically nor economically possible to

¹¹⁰ Physician's Report.

¹¹¹ The number of practices reached 155; the number of additional assistants varied from time to time.

¹¹² Dewar Report, p. 28.

develop modern specialist services. Improvement grants were given on an *ad hoc* basis to the existing hospitals that were judged to be of useful size. In 1924 a full time consultant surgeon was appointed at Stornoway on a trial basis. The results of the experiment were impressive. In addition to the care of inpatients, the consultant was able to offer an outpatient service: before his appointment, the total number of outpatients seen at Stornoway each year had been seven; six years later that number had grown to 1,690.¹¹³ It could now be seen that in-patient hospital care offered advantages in treatment that outweighed the reluctance of the sick to be moved from their homes. At Stornoway alone admissions more than trebled between 1915 and 1923 and the number of operations more than doubled.¹¹⁴

In 1929 the period for which the original annual HIMS grant had been voted had come to an end and the HIMS came under the direction of the Department of Health for Scotland. The annual grant of £42,000 was continued indefinitely along with 'such sum as may be voted annually'. The £10,000 transferred annually to the Highlands and Islands (Medical Services) Fund from the Scottish National Insurance Funds to pay for mileage incurred by doctors in attending insured patients, was now added to the Highlands and Islands (Medical Services) Grant rather than made as part of it. Since the general practitioner service was judged to be well founded it was decided that it should continue 'without material alteration'¹¹⁵ and all new money was devoted to extending specialist services. Further improvement grants were made to the managers of the hospitals at Lerwick, Kirkwall, and Stornoway, to the local authorities in Ross and Cromarty and in Caithness in respect of hospitals in Wick and Thurso, and to the trustees of the Belford Hospital at Fort William. The Royal Northern Infirmary at Inverness¹¹⁶ was given financial encouragement to act as an

¹¹³ Crosfil, op.cit., p.124.

¹¹⁴ Ibid.

¹¹⁵ *Annual Report of the Department of Health for Scotland*, 1929, Cmd.3529, p.114.

¹¹⁶ Although the Royal Northern Infirmary served the region, Inverness was not formally within the Crofting Counties.

up-to-date and fully equipped centre for all specialist services for the whole region so that only cases of unusual difficulty need be referred out of the region to the teaching hospitals of Glasgow or Aberdeen. The Inverness Infirmary had received intermittent subsidies from the beginning but in 1930 this support was confirmed as an annual grant of £5000 for ten years.¹¹⁷ Staffing of the local hospitals within the Crofting Counties had originally been by GP specialists. In 1929 the trial appointment of a specialist surgeon at Stornoway was made permanent and other appointments followed. By 1934 there were full time consultant surgeons in Shetland, Orkney, Caithness and Lewis.¹¹⁸ In 1935 a consultant physician was appointed at Inverness, contracted to provide consultant out-patient services on a regular basis at all the HMS hospitals.¹¹⁹ To facilitate and encourage the use of the expanding hospital and specialist services, additional grants were made to local authorities to promote and support ambulance services.

Glasgow became the preferred centre for tertiary referrals following the setting up of an Air Ambulance service in 1933. This service sprang from the initiative of a general practitioner on Islay who, 'despairing of the life of a patient too ill to stand the long journey to hospital by sea and road,'¹²⁰ persuaded a pilot of Midland Scottish Air Ferries to fly his patient to Glasgow. This led to requests for similar help from other doctors in other parts of the Highlands and Islands. The Air Ambulance, now operated on a regular contract basis by Scottish Airways Limited, soon became an essential part of the hospital service. In 1935 there were eight emergency Air Ambulance Service flights in 1935 and by 1938 this had increased to 34 all financed by the local authorities with two thirds of the cost refunded by the HMS. Until 1939 the Air Ambulance was based at Renfrew serving only airfields in

¹¹⁷ *Annual Report of the Department of Health for Scotland*, 1930, Cmd. 3860, p. 93.

¹¹⁸ *Annual Report of the Department of Health for Scotland*, 1935, Cmd. 5123, p. 98.

¹¹⁹ *Ibid.*, p. 99.

¹²⁰ J. Smith, 'The Scottish Air Ambulance Service,' *The Practitioner*, clxx, 1953, p. 67.

Kintyre, the Hebrides and Orkney but during the war years the service extended as more airfields became available. By 1948 the annual number of flights had increased to 245 carrying 275 patients over a total distance of 65,000 miles.¹²¹

The Highlands and Islands Medical Service was finally absorbed by the National Health Service in 1948. But in effect it had begun to lose its separate existence during the preparations for the Second World War. By that time it had already been judged an outstanding success. It was said to have been conducted

in an atmosphere of sympathy and understanding between the central department and the doctors, nurses and other parties, and to the satisfaction of all concerned...The Highlands and Islands area is the only part of Scotland which has in effect a complete general practitioner service available for all classes and the Highland and Islands Medical Service works on the basis of co-operation between the State and doctors.¹²²

The HIMS had succeeded in all its primary objectives. In the Crofting Counties, subscribers to the National Health Insurance scheme were able to receive the full medical benefit to which they were entitled. The gross deficiencies in the medical services available to the population as a whole were made good. The acute distress that throughout previous centuries had been caused by the lack of medical help at times of crisis had been relieved.¹²³

The HIMS as a Pilot Study

Leslie Mackenzie, in his *Suggested Scheme for the Administrative Consolidation of Medical Services*,¹²⁴ declared that the creation of a comprehensive medical service

¹²¹ Ibid., p. 68.

¹²² Cathcart Report, p. 227.

¹²³ The parish ministers replying to the survey carried by the Royal College of Physicians in 1851 (Physicians Report, op.cit.) had not complained of any burden of disease or chronic illness. They had complained of lack of medical help in cases of accident or obstetric emergency.

¹²⁴ Dewar Report, p. 43.

for the Highland and Islands presented an opportunity ‘to show how far it is possible to bring about an administrative consolidation that would result in increasing the efficiency of the present services,...in developing the resources of the present services, in demonstrating what additional service is necessary and in preparing the way for any legislation afterwards found to be expedient.’¹²⁵ Mackenzie already saw the potential of the HIMS as the pilot for the later creation of a comprehensive state medical service. The medical members appointed to the Board of the HIMS in 1913 belonged to a medical profession in Scotland that had voiced its support for the 1909 Minority Report on the Poor Law¹²⁶ and was already suggesting schemes for the abolition of the Poor Law and the creation of a unified state health service.¹²⁷ There can be no doubt that, as leading advocates of medical reform, Leslie MacKenzie, John McVail, Sir Donald MacAlister and Norman Walker in 1913 and those who followed in the administration of medical services in Scotland in the 1920s and 1930s, had in mind the objective of a comprehensive health service at some time in the future. They agreed with Leslie Mackenzie that the launching of the HIMS was that ‘favourable occasion’ to demonstrate how such a service could be created and maintained.

The terms of the Highlands and Islands (Medical Service) Grant¹²⁸ made this entirely possible. They were framed to make certain that the services of a general practitioner would be freely available to all without any financial barrier, thus opening the way for the development of a demand led service. The terms of the Grant also made it possible for the Highlands and Islands Medical Service Board to expand the scope of general practice by removing the cost of treatment from both the doctor and the patient and by subsidising the incorporation of domiciliary nursing

¹²⁵ Ibid.

¹²⁶ *Edinburgh Medical Journal*, iii, 1909, p. 14.

¹²⁷ Ibid, p. 311.

¹²⁸ *First Report of the Highland and Islands Medical Service Board*, 1914, Cmd. 7977.

services in the structure of general practice. The Grant made provision for patients from the Highland and Islands to have access to specialist services at every level, including services that were not available within the administrative area of the Crofting Counties. The service became comprehensive in its scope and comprehensive in being freely available to all. The HIMS soon had all the elements of that 'comprehensive medical service for every citizen covering all treatment',¹²⁹ envisaged in the Beveridge Report in 1942 and provided the full range of 'the resources of medical skill and the apparatus of healing' that Aneurin Bevan aimed to organise after 1945.¹³⁰

As will be shown later in this thesis, the Cathcart Committee drew from the experience of the HIMS in making proposals for the future of medical services in Scotland in 1936.¹³¹ It would have been equally possible, in the urgent flurry of planning of a National Health Service that followed the publication of the Beveridge Report in 1942, to look again to the HIMS for guidance. As a pilot study the HIMS had much to offer – even more than Leslie Mackenzie could have anticipated in 1912. Unfortunately a number of its important lessons passed unnoticed in London. As a result there were many understandings and unnecessary conflicts that were still unresolved in the final months of planning the NHS and avoidable faults in the resulting structure of the Service. In Scotland the experience of the HIMS was one factor in protecting the National Health Service (Scotland) Act from the defects in the Act for England and Wales. In Scotland the HIMS also served as an early introduction and an encouraging prelude to the NHS of 1948.

In 1913, when the HIMS was created the effects of a medical service, freely available and comprehensive in its scope, on the health of the community were still unknown. Nor was there any experience of how a free, and therefore demand led,

¹²⁹ *Report of the Commission on Social Insurance and Allied Services*, 1942, Cmd. 6404. (Beveridge Report) Medical provisions discussed in *BMJ*, ii, 1942, p. 704.

¹³⁰ Aneurin Bevan, *In Place of Fear* (London, 1952), p. 75.

¹³¹ Cathcart Report, pp. 221-232.

service would respond to public demand. The HIMS was set up as an expedient to meet an immediate need in 1913 but in retrospect it can be seen that its performance over the years to 1945 can be assessed for its potential as a pilot for the creation of a comprehensive free and demand led National Health Service after the War.

The Trial Population

Although the Crofting Counties made up a unique region of Britain in 1913 it can be shown that at that time the people offered an acceptable model for the population of Scotland in 1945 when crucial decisions were made about the future of the NHS. The age and sex structure of the population of the Crofting Counties in the early years of the twentieth was the product of levels of fertility and nuptuality and patterns of migration and emigration that were significantly different from those of Scotland at that time.¹³² However, the structure of population of Scotland changed significantly in the early decades of the century. As a result the sex and structure the population of Scotland in 1945 was remarkable similar to the structure of the population the Crofting Counties when the HIMS was introduced. In this parameter the trial population is therefore acceptable. (Table 1)

In spite of their poverty, the crofters in 1913 were a healthy people. The health statistics reveal a huge difference between the population of the Crofting Counties and the general population of Scotland. In the nineteen century the difference was so remarkable that some believed that the constitution of the Highlander must be in some way different from that of the people of the south. If that had been the case the HIMS could not have served as a pilot study for a health care system to be introduced elsewhere in the United Kingdom. However there is good evidence that throughout the nineteenth century the population of the Highlands and

¹³² M. Anderson and D. J. Morse, 'High Fertility, High Emigration, Low Nuptuality: Adjustment Processes in Scotland's Demographic Experience,' *Population Studies*, xlvii, 1993, p. 324.

Islands enjoyed the benefits of space, fresh air and sunlight and, provided harvests were normal, an excellent diet.¹³³

Table 1.

Population Structure: Crofting Counties in 1911 & Scotland in 1911 and 1951

	Aged (0-14) %	Aged 65+ (%)	F/M Ratio
Scotland - 1911	32	5	106
Crofting Counties- 1911	28	12	109
Scotland - 1951	25	10	109

Source: Calculated from *Census of Scotland*, 1911 & 1951

They also escaped the suppression of physical growth and the debilitation so evident in the people subjected to the living conditions of the Lowland industrial centres.¹³⁴ The expectation of life was greater than elsewhere in Scotland and a high proportion of the population achieved their three score years and ten. In 1860, for example, the proportion of the population surviving longer than 75 years was four times greater in Argyre than in Glasgow. The difference between the population in the Highlands and Islands and that in the industrial south narrowed towards the end of the century but was still significant when the HIMS was introduced in 1913. (Table 2. The comparative rates of deaths of those over 75 years is used as an index of survival).

¹³³ Napier Report, p. 74; E. P. Cathcart and A. M. T. Murray, *A Study in Nutrition: An Inquiry into the Diet of Families in the Highlands and Islands of Scotland* (London, 1940).

¹³⁴ The First Statistical Survey and the Physicians' Report provide anecdotal evidence. Satisfactory evidence is given by W.W. Knox, *Hanging by a Thread; The Scottish Cotton Industry* (Preston, 1995); C.A. Whately, 'Women and the Economic Transformation of Scotland,' *Scottish Economic and Social History*, xiv, 1994; C.A. Whately, *The Industrial Revolution in Scotland* (Cambridge, 1997), p. 74.

Table 2

Deaths Rate (per 100,000) over 75 years of age.					
	1860	1913		1860	1913
Shetland	470	689	Glasgow	118	134
Orkney	412	620	Edinburgh	223	214
Caithness	351	594	Dundee	164	184
Sutherland	451	735	Aberdeen	246	247
Ross & Cromarty	394	534	Paisley	269	141
Inverness	393	481	Leith	189	144
Argyll	519	472	Greenock	164	165

Source: Calculated from the *Annual Reports of the Registrar General for Scotland*.

The *Annual Reports of the Registrar General for Scotland* also show that the people of the Crofting Counties suffered less from the infectious diseases that were so fatal in the industrial communities of the south. This was best indicated by the difference in the death rates of children under 5 years, the chief victims of the zymotic diseases. Although the death rates from these infections declined in all parts of Scotland during the second half of the nineteenth century, the difference between the rates in the Crofting Counties and those in the large towns was still very clear in 1913. (Table 3)

Table 3

Death Rate (per 100,00) Children under 5 years of age					
	1860	1913		1860	1913
Shetland	104	48	Glasgow	1107	236
Orkney	67	24	Edinburgh	415	110
Caithness	199	62	Dundee	754	180
Sutherland	103	31	Aberdeen	701	250
Ross & Cromarty	231	39	Paisley	784	167
Inverness	188	71	Leith	705	151
Argyll	222	11	Greenock	784	289

Source: Calculated from the *Annual Reports of the Registrar General for Scotland*

The Infant Mortality Rates also show a distinct and continuing trend. (Table 4)

Table 4

Infant Mortality Rate -1860 and 1913					
	1860	1913		1860	1913
Shetland	53	60	Glasgow	182	129
Orkney	41	77	Edinburgh	156	101
Caithness	107	111	Dundee	185	162
Sutherland	82	52	Aberdeen	148	153
Ross & Cromarty	110	58	Dundee	237	118
Inverness	117	84	Leith	153	120
Argyll	86	70	Greenock	154	116

Source: Calculated from the *Annual Reports of the Registrar General for Scotland*.

That the population of the Highlands and Islands enjoyed better health than the industrial population in Scotland was not evident to those whose only experience of highlanders was of the highlanders who had migrated to the south. There they were obviously different, poor, badly clothed, and strangely prone to disease.¹³⁵ Highland migrants arriving in the south often succumbed to infections that did not have a high mortality among the local population. Many of those who had observed the difficulties in adapting to urban living suffered by migrant Highlanders - especially those observers who had also visited the Hebrides and had seen the primitive 'black houses' with their chimneyless turf roofs and their earth floors - came to regard the people of the Highlands and Islands as a race apart with a different life style of poverty and primitive living and with a different pattern of disease and disability. Had that been so the Crofting population could not have served as a valid model for a trial of a health care system for any other part of the United Kingdom.

The explanation for the seemingly peculiar susceptibility of the people of the Highland and Islands to disease came later in the twentieth century. For generations the people of this remote part of the country had been without contact with the diseases endemic in the industrial south, producing a population that, in relation to the outside world, was immunologically naive.¹³⁶ Many of young people who migrated for spells of employment in the south proved to be highly susceptible to infection, particularly to pulmonary tuberculosis. All too often they returned home to die of a tubercular infection that they had been unable to contain. As social

¹³⁵ In Glasgow this had been remarked on from early in the 19th century: 'On looking over the reports regarding our infirmary, I find an amazing number of highlanders among the inmates; and I find that in Albion Street Hospital, in one year 40% of the patients were from the Highlands and Islands.' R. Cowan, *Vital Statistics of Glasgow* (Edinburgh, 1838), p. 30.

¹³⁶ Even at home they could be seen to be vulnerable. When the occasional visitor brought his common cold to the Highlands it spread rapidly as the 'boat cough,' seriously disrupting the local community. The parishes that included the ports of Helmsdale, Stornoway and Wick suffered particularly from these minor epidemics at the height of the winter and spring fishing seasons.

intercourse with the south increased toward the end of the nineteenth century, the number of deaths from pulmonary tuberculosis in the Highlands and Islands increased¹³⁷ and, by 1913, the death rate from tuberculosis had become almost as great as in Scotland's large towns. (Table 5).

Table 5

Death Rate from Pulmonary Tuberculosis

	1913
Crofting Counties	1.17
Lowland Large Burghs	1.27
Scotland	1.04

Source: *Annual Report of the Registrar General for Scotland*

That the crofting community in 1913, in its home environment, was healthier than the general population of Scotland¹³⁸ was not however entirely due to the relative freedom from exposure to virulent infection. The traditional diet of the crofting community, still almost unchanged into the first decades of the twentieth century, was found on investigation to be superior, both in calorific value and in first class protein, to that of other industrial communities in the United Kingdom.¹³⁹ Housing conditions were also much less threatening than had been supposed by casual visitors. The Census of 1911 showed that the houses of the crofting population were

¹³⁷ It may be assumed that most of those who died of tuberculosis were returned migrants. The statistics do not show if any substantial number acquired their infection without leaving the Highlands.

¹³⁸ The stature and vigour of the people was evident in the recruiting for the Boer War. The Highland regiments were able to maintain their standards while, in order to find sufficient numbers in the industrial south, the general limit for recruitment to the British army was reduced from 5ft 3ins. to 5 ft. Napier Report, p. 36.

¹³⁹ Cathcart and Murray, op.cit.

less crowded than houses in semi-rural areas in the Lowlands or in the great cities.
(Table 6)

Table 6

Housing: Overcrowding - 1911	
	Persons per Room
Crofting Counties	1.13
Ayrshire	1.5
Glasgow	1.91

Source: Calculated from *Census of Scotland, 1911*

A comment in the Napier Report in 1884 still held good in 1913:

Among the various inconveniences which the people of the Highlands and Islands suffer in connection with their position as occupiers of land, the one which strikes the stranger as the most deplorable, and which affects the natives with the least impatience is the nature of their dwellings... In the main his house does not make him unhappy, for he does not complain; it does not make him immoral, for he is above the average standard of morality in his country; it does not make him unhealthy, for he enjoys an uncommon share of vigour and longevity.¹⁴⁰

The difference in the health of the population of the Crofting Counties and the people of the Lowlands to in 1860 can be attributed entirely to the debilitating effect of living conditions in the industrial south. As conditions improved for the industrial population the health standard of the two communities came closer together. (Table 7 and Figures 1-5)¹⁴¹

¹⁴⁰ Napier Report, p. 48.

¹⁴¹ Ayrshire, as both agricultural and industrial, is taken to represent the Lowlands generally and Glasgow to represent the urban industrial populations of Scotland's cities.

In spite of the very great differences in the health of the crofting population and that of Scotland as a whole in the nineteenth century these differences had become less by 1913 and had become insignificant by 1945. These changes can be entirely attributed to change in social conditions. There is therefore no evidence of any inherent difference (genetic or otherwise) between the two populations which would make the population of the Crofting Counties unsuitable as a trial population for a health program to be introduced for the whole of Scotland. The health standards of the crofting population at the beginning of the 'trial' were close enough to the standard in Scotland in 1945 to allow useful comparison between the experiences of the two populations. (Table 7)

Table 7

Death Rates: Crofting Counties and Scotland			
	1860	1913	1945
Death Rates			
Crofting Counties	14.9	14.3	12.2
Scotland	20.7	15.5	13.2
Infant Morality Rates			
Crofting Counties	85	74	53
Scotland	121	109.6	60
TB Mortality Rate			
Crofting Counties	1.42	1.17	0.53
Scotland	2.37	1.04	0.62

Source: Calculated from the *Annual Reports of the Registrar General for Scotland*

The population of the area served by the HIMS was eminently suitable for an experiment. It was stable and well defined geographically; there were no other significant health systems that might have influenced health trends within the area over the 'trial' period from 1913 to 1948.

Comparative Health Trends in Scotland

In assessing the effects of a health service the ideal would be to measure the subjective health experience of the people. In practice it is only possible to measure health by its absence as revealed in 'health' statistics based on the recording of identifiable events. The most certain recordable event is death; notification of illness is much less certain but is useful for purposes of comparison. Review of statistics of the *Annual Reports of the Registrar General for Scotland* from the period from 1860 to 1945 therefore provides the best available background against which to comment on the health benefits of the HIMS.¹⁴²

Figures 1-5 show the trends over the whole period from the time when records were first kept until the end of the Second World War, including the 'trial' period from 1913. Over the whole period from 1860 the health statistics of the Highlands and Islands¹⁴³ showed a continuous steady improvement and give no indication that the introduction of the HIMS in 1913 caused any break in the continuity of that trend. In the Highlands and Islands the Infant Mortality Rate fell progressively from the end of the nineteenth century. (Figure 1) The main factor was the decline in fertility (reflected in the birth rate) which resulted in smaller families. (The chances of infants surviving increase as the number of children to be fed and cared for by the mother decreases; the relation of a falling birth rate and the Infant

¹⁴² *Annual Reports of the Registrar General for Scotland*. Statistics from the period from 1860 to 1945 have been brought together in Appendix II and have been used to prepare Figures 1-5.

¹⁴³ Appendix III

Figure 1



Mortality Rate is shown in Figure 2.) Over the same period the Infant Mortality Rate fell in Scotland generally, the fall beginning later but then continuing at a faster rate (Figure 1). A fall in the birth rate contributed to this rapid fall in the IMR after the first decades of the century but the major factor was the progressive recovery of the great mass of the Scottish population from the poor nutrition and debilitating living conditions in the industrial centres at the beginning of the century.

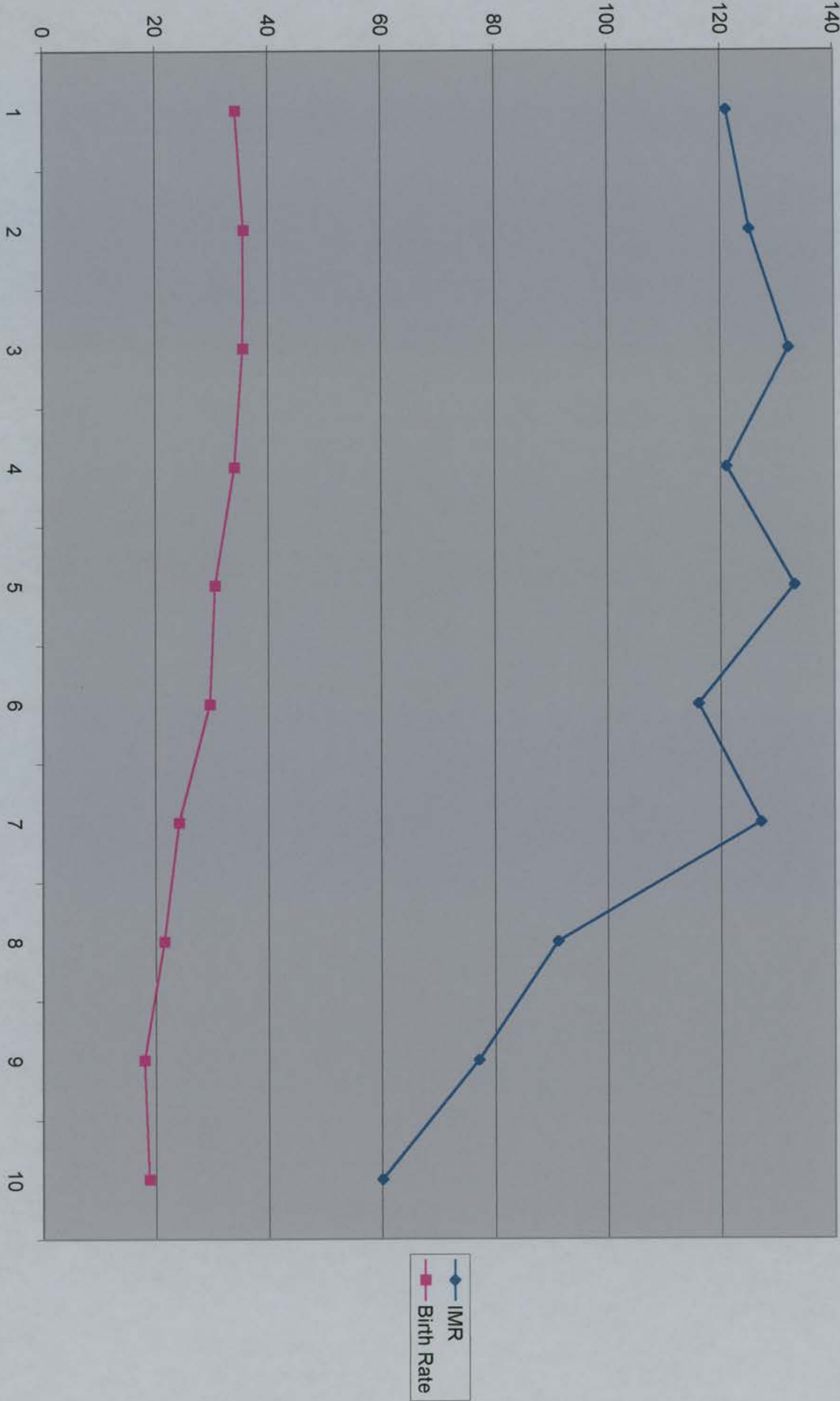
In the nineteenth century the overall Death Rate in the Highlands and Islands was significantly lower than elsewhere in Scotland. (Figure 3) The apparent downward trend after 1915 is the statistical effect of an ageing population that obscures the true extent of the prolongation of life. In Scotland generally, as social conditions improved from the end of the nineteenth century, the Death Rate began to conform to that in the Highlands and Islands so that by 1945 the death rate had become similar across Scotland. (Figure 4)

Only the death rates from pulmonary tuberculosis show a different pattern. From 1860, when records began, until the end of the nineteenth century the Highland and Islands had less experience of pulmonary tuberculosis and suffered fewer deaths. When the Highlands and Islands became less isolated at the turn of the century the experience of tuberculosis became similar in all parts of Scotland. Between 1900 and the end of the 1930s the population of the Highlands and Islands was slow in developing resistance to the disease as shown by a greater death rate. Thereafter the experience of tuberculosis became more uniform across Scotland. (Figure 5)

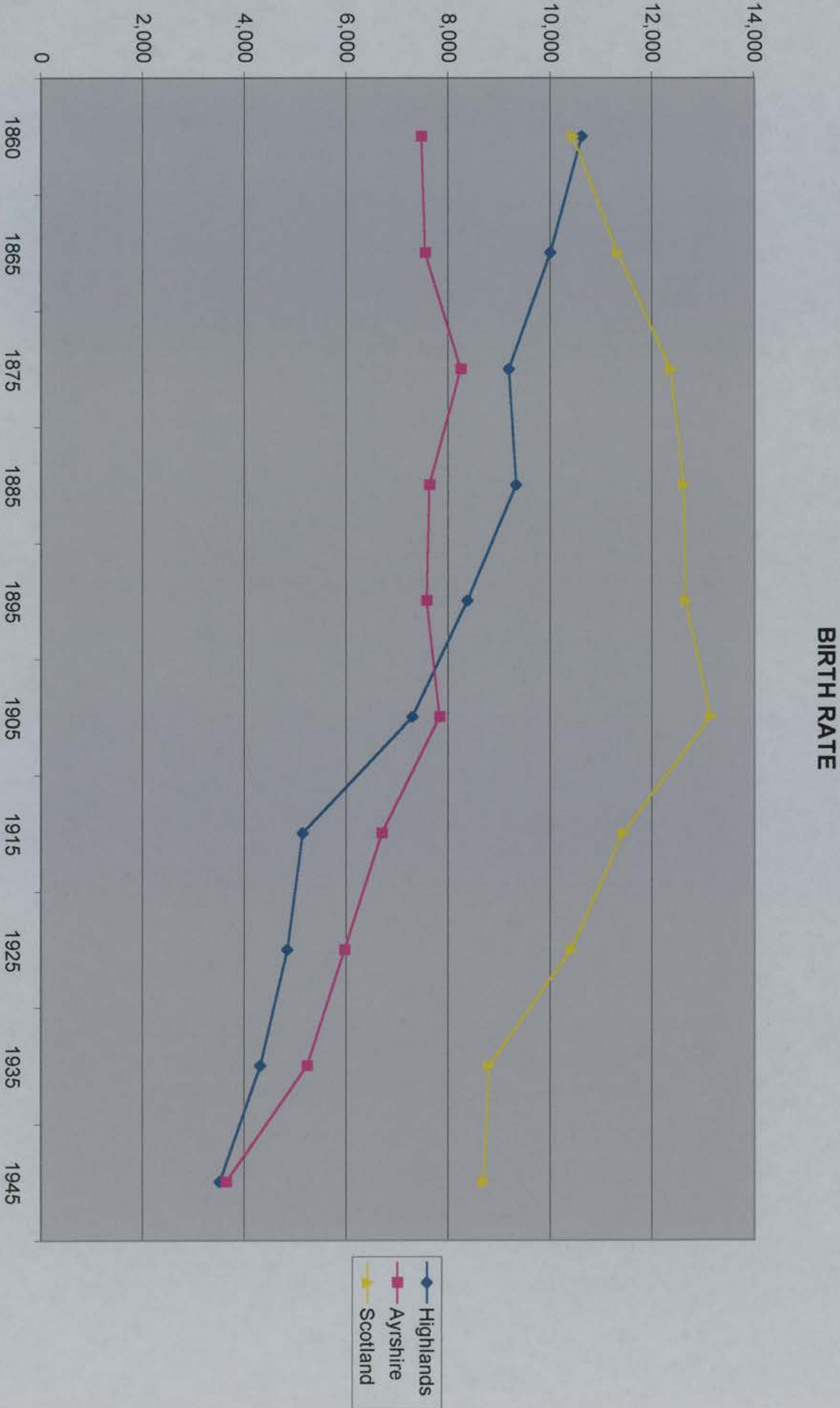
The evidence of these various trends indicates that the major improvements in health in the different parts of Scotland were essentially the result of general social change. The remarkable improvements in the indicators of health in the industrialised areas plot the continuing recovery of the population from the appalling urban deprivation and the resulting physical degeneration of the early nineteenth century. The standards of health of the population of the Crofting Counties showed a slow but

Birth Rate and Infant Mortality Rate - Scotland 1860 - 1945

Figure 2



Source: Annual Reports of the Registrar General for Scotland



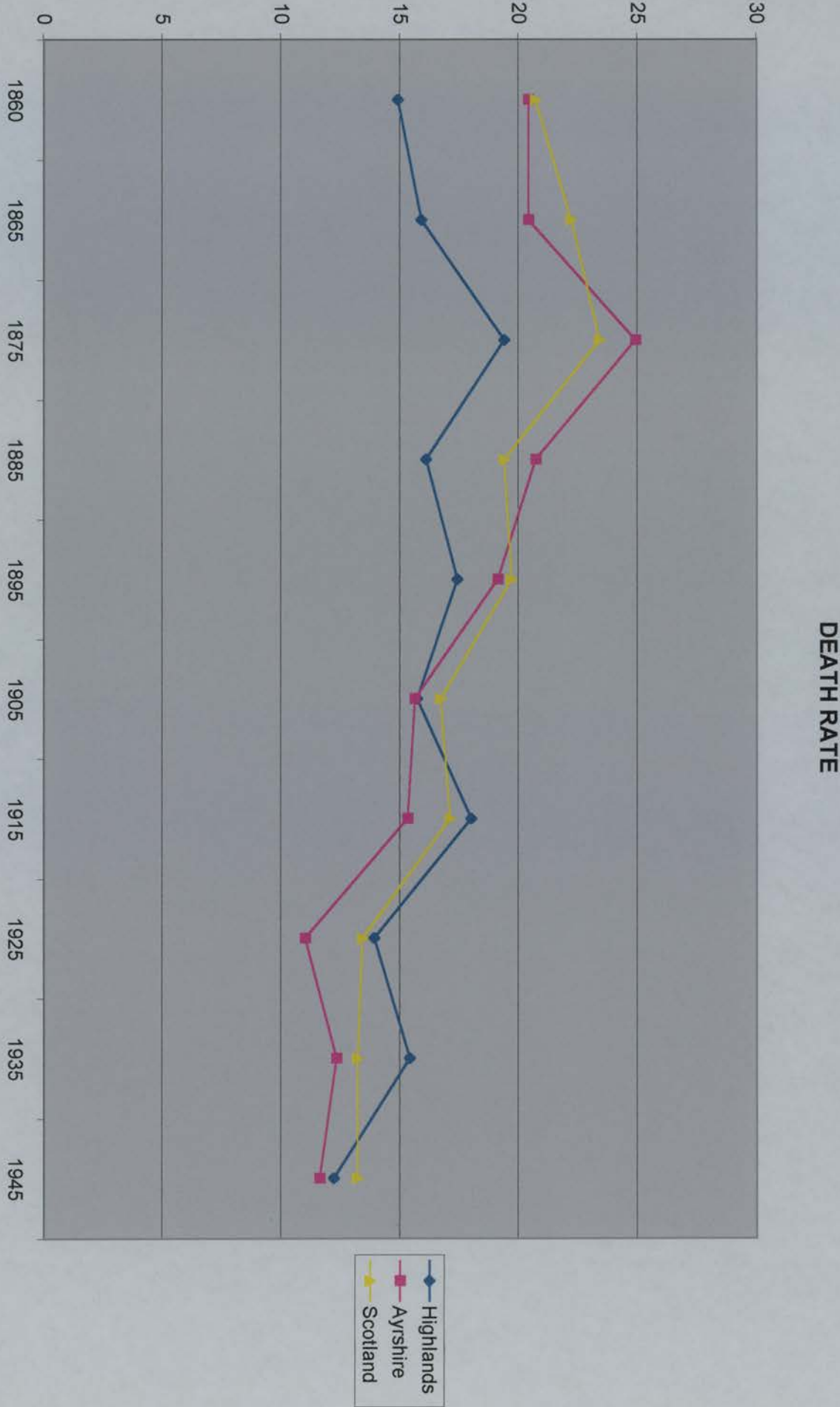
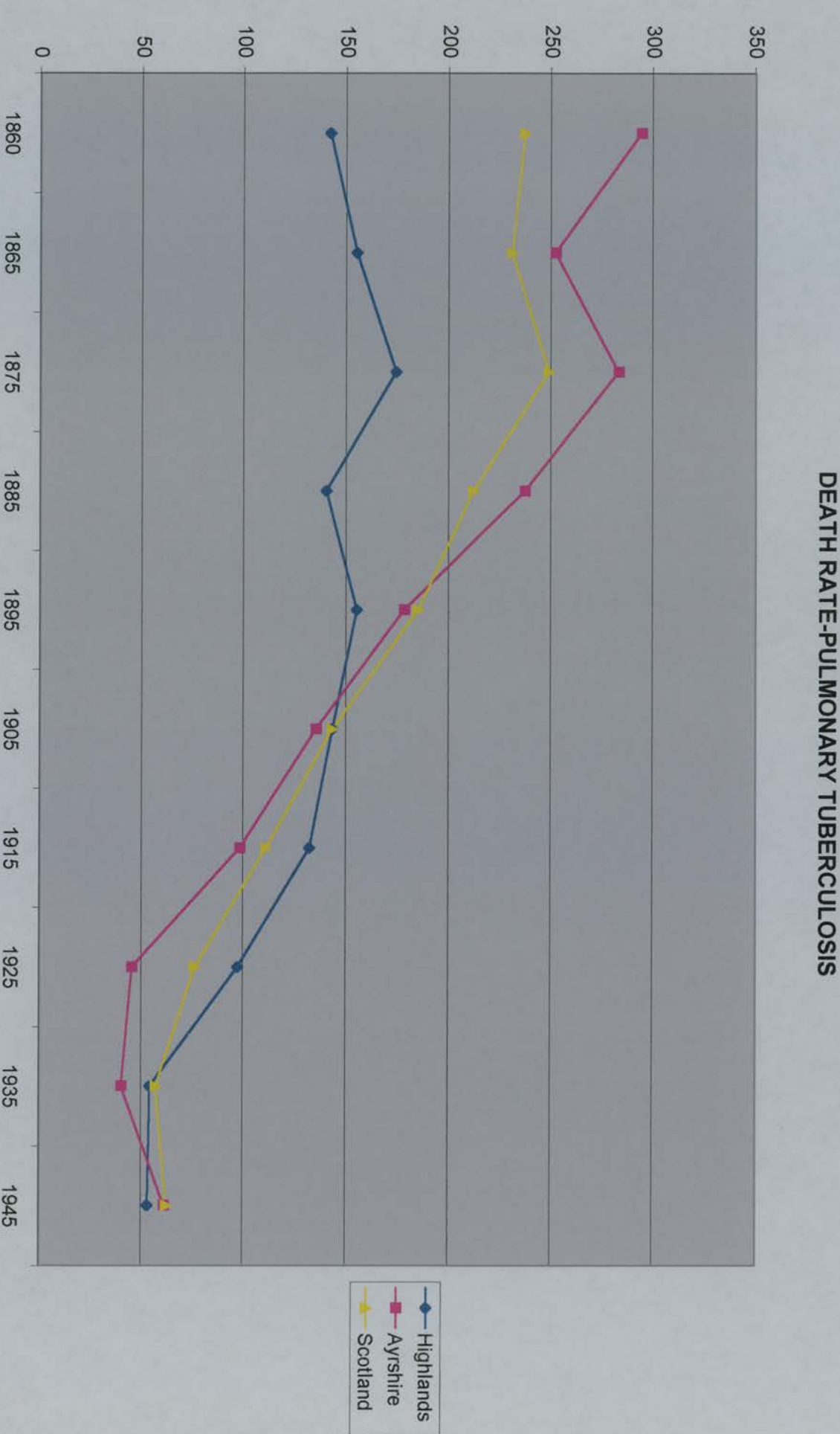


Figure 5

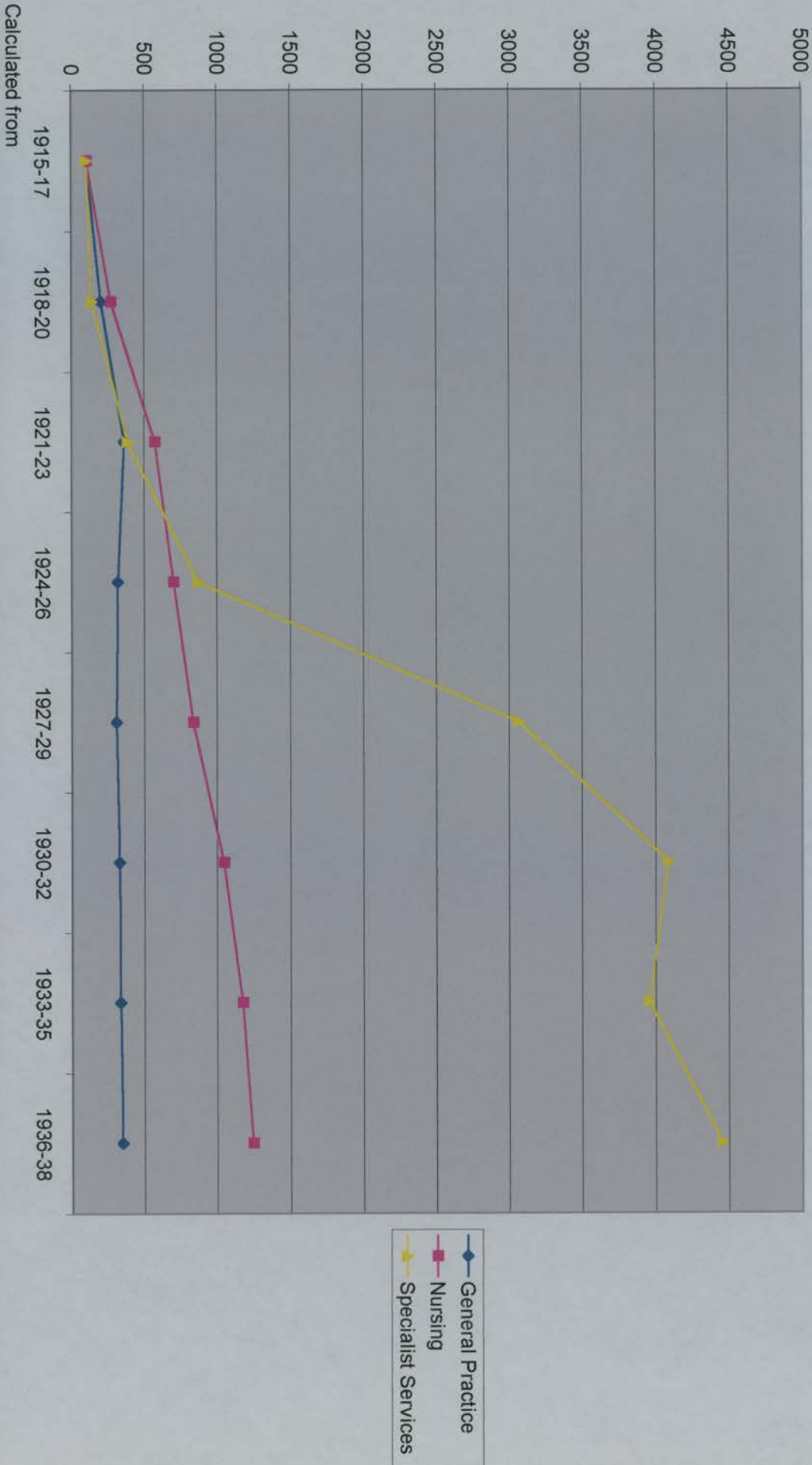


still distinct improvement after 1913 but this was a continuation of a trend already established and cannot be attributed to the medical care provided by the Highlands and Islands Medical Service. Over the same period from 1913 until 1948, it was in those Lowland parts of Scotland, which had no comprehensive state medical service, that the statistical indicators of 'health' improved most rapidly. There was no evidence that over this period the institution of a universal and free system of medical care made any improvement in health trends to compare with the changes achieved by improved social conditions alone.

A Comprehensive Service and the Cost to the State.

Although the success of the HIMS is not quantifiable in terms of crude health statistics it was an undoubted success by popular acclaim. The experience of the HIMS demonstrated the interesting paradox that as the health of the population improved the medical services were used more rather than less by the 'healthier' population. As new services became available they were eagerly taken up. Figure 6 shows that the cost of general practitioner services increased but soon reached a plateau. As the potential of domiciliary nursing came to be more fully appreciated, both by doctors and patients, demand increased; more nurses were employed and the cost of nursing services increased before reaching a steady level. When limited specialist services became available in 1924 and were extended after 1929 it became evident that, in a demand led system, the appetite for the demand for more sophisticated forms of investigation, new technical procedures in treatment, and the products of advances in medical science promised to be infinite at no demonstrable benefit to the community or the state. Whether a comprehensive demand led service, provided out of public funds, was of advantage to the state remains a complex question. Politically, the HIMS may have helped to prevent disaffection in one corner of the country. Administratively it undoubtedly solved a problem in social

Percentage Increase in Expenditure



management. But in serving the state by improving the health of the population, by the conventional indices it could claim no measurable success.

Recruitment - General Practitioners

The Highlands and Islands Medical Service Board found that even in a demand led services it was possible to determine an optimum complement of doctors that would maintain general practise at its maximum level of efficiency. Experience discovered that in the circumstances of the Crofting Counties in the late 1920s and 1930s this optimum number was approximately 170. A smaller number of doctors would have found it impossible to maintain a satisfactory standard of care and many would have been grossly overloaded; a larger number would have been unnecessarily expensive and would not have provided every doctor with a sufficient clinical load to allow him to maintain his clinical skills. It was found that on average each general practitioner, for maximum efficiency, should have the care of approximately 2000 patients.

It had soon become evident that there was no shortage of well-qualified and committed doctors eager to find employment in a state service administered by a central government department.¹⁴⁴ The attraction for doctors lay in security of tenure with guaranteed periods of subsidised study leave, the opportunity to attend their patients uninhibited by the cost of transport, the freedom to prescribe for their patients without crippling financial constraint, and practice arrangements that included the co-operation of nursing staff and a full range of supporting services. Given such conditions general practitioners were happy to be employed by the state. The HIMS allowed general practitioners to take on private patients at modest fees. But in the case of the lower income patients, who made up the great majority of patients in the crofting communities, fees were neither requested nor received

¹⁴⁴ The BMA in Scotland did not adopt the confrontational attitude that characterised the parent body in London over the introduction of the National Health Insurance Scheme in 1911. The BMA took no part in the founding of the HIMS but was consistently co-operative thereafter.

provided the doctor had a secure income from some other source.¹⁴⁵ General practitioners were not debarred from entrepreneurial private practice but the Scottish doctors in the 'trial' did not find this essential to their standing as independent professional men. Employment by the state did not deprive them of clinical freedom provided they had security of employment and were not subjected to the vagaries and unpredictable demands of employment by local authorities. In the last years of HMS the average income from the state of its general practitioners was £800 per annum¹⁴⁶ and this had proved to be readily acceptable. Yet at this time, in 1943, the leadership of the BMA refused to countenance any form of employment by the state that did not offer an income of over £1,000.¹⁴⁷ The BMA leaders also continued to protest that employment by the state posed a threat to the 'traditional freedoms' of doctors and claimed that 'to convert at a stroke one of the oldest and most honourable profession into a public service, amenable to all the discipline which public service involves, is an operation quite without precedent.'¹⁴⁸ A precedent already existed in the HMS which had shown that many doctors were more than willing to opt for state service in preference to a career in entrepreneurial practice, which for the great majority, meant a financially precarious existence and little professional satisfaction. In the HMS general practitioners found their terms of employment attractive and in return provided an excellent and committed service. The assumption made by the Ministry of Health, that it would be impossible to maintain discipline and to ensure a satisfactory standard of performance unless general practitioners were salaried employees of the state¹⁴⁹ was also demonstrably unfounded.

¹⁴⁵ Blackden, op.cit. p. 59.

¹⁴⁶ J. Ross, *The National Health Service in Great Britain* (Oxford, 1952), p. 66.

¹⁴⁷ Honigsbaum, op.cit., p. 62.

¹⁴⁸ Webster, op. cit., p. 38.

¹⁴⁹ Pater, op. cit., p. 37.

Recruitment -Nursing Staff

The general practitioners services on the HIMS functioned efficiently with a staff of some 170 doctors. This was only possible when the organisation of each doctor's practice did not require him to supervise in person the full course of every treatment prescribed. Without nursing services as an integral part of the practice organisation many prescribed treatments would have been abandoned, assistance at births would have been less certain (page 28) and in most practices all efforts towards health education and prevention would have been abandoned for lack of time. For over thirty years the HIMS demonstrated that, together, general practitioners and nurses formed an efficient and cost effective partnership. Yet no provision was made in the NHS Acts to incorporate nursing service in general practice. The importance of nursing to domiciliary medical practice was not recognised in the planning of the NHS and nor was it recognised for many years as the service expanded and developed. The experience of the HIMS had demonstrated that there would have been no shortage of well-qualified applicants for posts as district nurses in an integrated general practitioner services, an arrangement that would have been of great benefit to the public.

Recruitment - Consultants and Specialists.

The first full-time surgeon in the HIMS was appointed in 1924. There was no shortage of applicants for this salaried post or for those that were created in the following years. As the hospital service grew the university medical schools saw a new opportunity for their specialists in training. Salaried posts in the HIMS offered opportunities for men who wished to develop a specialist career but who were unable to finance the traditional and inevitable waiting years at the teaching centres in the cities before they could become established. In 1931, a surgeon was appointed to the HIMS at Wick, nominated by the Professor of Surgery at Aberdeen for a limited tour

while, as recorded in the *Annual Report of the Department of Health for Scotland*, 'his positions in relation to the University and the Infirmary were not to be diminished'. This and later similar appointments attracted highly skilled candidates and made good specialist services widely available outside the main medical centres. This early move to involve university medical schools in the state medical services was followed elsewhere in Scotland from 1932.¹⁵⁰ The value of this association between the teaching centres and the peripheral services was recognised and exploited in the National Health Service (Scotland) Act to the great advantage of the NHS in Scotland. This lead was not followed in England where teaching hospitals were allowed to distance themselves from peripheral services. The Ministry of Health was not persuaded of the value of a fully integrated hospital service and in the years of negotiation in the 1940s, the leaders of the BMA seemed oblivious to the new opportunities that a salaried state service offered to medical graduates of limited means who wished to make a career outside general practice.

Regionalisation of Hospital Services

In 1940 the Ministry of Health believed that the regionalisation of hospitals, organised at that time as a wartime expedient for the care of casualties, would be 'irrelevant to a peace time service'.¹⁵¹ The Ministry, however, was convinced that the most efficient administrative units for hospital administration in a state service were the counties and county boroughs.¹⁵² This followed from a conviction that 'no government would wish such a service to be administered by the minister direct'.¹⁵³ The management of the hospitals, it was thought, must be in the hands of the local authorities and they were not organised on a regional basis. By then the HIMS had

¹⁵⁰ In 1932, university professors of Medicine, Surgery, Obstetrics and Gynaecology, and Child Life and Health became responsible for the care of patients in Edinburgh's three municipal hospitals. The other Scottish universities made similar arrangements.

¹⁵¹ Pater, *op.cit.*, p. 24.

¹⁵² *Ibid.* p. 27.

¹⁵³ *Ibid.*, p 26.

been operating very successfully on a regional basis for twenty-five years and the local authorities had made it clear that they were unwilling to accept this additional responsibility. It had also been found that 'medical and other opinion is emphatically against it.'¹⁵⁴ Local authorities were themselves more than ready to acknowledge that the hospital service was best managed on a regional basis and under the control of a central government department.

Already in 1941 the Ministry had decided that however other hospitals were organised, teaching hospitals should be given separate and special status.¹⁵⁵ In the Highlands and Islands it had been found that the teaching hospitals of the university centres and the local hospitals could work together within the system to their mutual advantage. The HIMS had built up a sound hospital service on the basis of the existing voluntary hospitals and its grants were made to the voluntary hospitals' governing bodies. But how hospital and specialist services should be developed and how consultants should be appointed was determined by general agreement in each district. In 1916 the Board convened in each of the Crofting Counties a meeting of County and District Medical Officers of Health, the School Medical Officers, representatives of Local Medical Committees and Panel Committees under the National Insurance Act, a representative from each of the Secondary Education Committee and the principal medical officer of each of the general hospitals to advise of general policy.¹⁵⁶ It is significant that, although the state financial support was being given directly to the voluntary hospitals, each of these committees was chaired by the County Convenor. These meetings established a habit of co-operation that continued until 1948. The Ministry of Health had been less active and therefore less successful in bringing the hospital systems of England and Wales together in the years between the wars. When planning for the NHS began in London in 1938 there

¹⁵⁴ Cathcart Report, p. 231.

¹⁵⁵ Pater, *op.cit.*, p. 27.

¹⁵⁶ *Annual Report of the Highlands and Islands Medical Service Board*, 1916, Cd. 8246, p.15.

was no beginning of a consensus¹⁵⁷ on which to build and the various medical bodies stood firm in protection of their own interests.¹⁵⁸ The HIMS had shown that there was no intrinsic incompatibility between local authorities and voluntary bodies and that the open and bitter conflicts that occurred in London were not inevitable.¹⁵⁹

The Local Authorities in a Comprehensive Medical Service

Efficient general practice was of great benefit to the local authority health services. From the beginning the Highlands and Islands Medical Service Board decided that no direct financial support would be given to local authorities in carrying out their responsibilities under the Poor Law Acts or the Public Health Acts.¹⁶⁰ However the local authorities did benefit indirectly. A larger number of doctors became available on a part time basis to provide the necessary medical services for the poor and the larger number of general practitioners ensured that problems discovered by the Maternity and Child Welfare Clinics and the School Medical Service could be referred to the appropriate general practice in the confident expectation that the necessary investigation and treatment would be carried out.

On the other hand, in 1936 the Cathcart Committee found that the only medical services in the Highlands and Islands that had not reached a satisfactory level of performance were those which remained completely in the control of the local authorities.¹⁶¹ The local authorities had themselves made it plain that they did not wish to increase the level or scope of their responsibilities. This experience of the HIMS carried no weight with the Ministry of Health. From its foundation in 1919

¹⁵⁷ Pater, op.cit, p. 23.

¹⁵⁸ For convenience Pater, who personally witnessed the disputes within the Ministry of Health, is given as the only reference. Many other historians have confirmed that they took place.

¹⁵⁹ Pater, op.cit., p. 29.

¹⁶⁰ *Annual Report of the Highlands and Islands Medical Service Board*, 1916, Cd. 8246, p. 12.

¹⁶¹ Cathcart Report, p. 231.



until the very last stages of the planning of the National Health Service, the Ministry held to the view that any state medical service should be provided at local authority level. Pater makes clear the strength of the conviction of Sir Robert Morant, the first Permanent Secretary, and his successors at the Ministry, that this must be so.¹⁶² In London and the other great urban centres, local authority services could be efficient and effective, but the experience in the Highland and Islands showed that such high standards were impossible in sparsely populated and poorly financed rural areas. The failure of the Ministry to give weight to this evidence, and to the bad reputation of all but the largest local authorities as poor employers, prolonged the anxieties and resistance shown by the medical profession during the planning of the NHS.

The Establishment of Consensus.

The spirit of co-operation established in the organisation of the specialist and hospital services of the HIMS extended to other organisations. The District Nursing Associations had been co-operative from the beginning. The Northern Hospital at Inverness, although not eligible for a grant from the Highlands and Islands Medical Service Fund,¹⁶³ agreed informally in 1919 to act as a secondary referral hospital for the HIMS.¹⁶⁴ From 1919 the St Andrew's Ambulance Service, a charity organisation, provided a motor ambulance at each of the general hospitals. The voluntary assistance of the Midland Scottish Air Ferries led on the establishment of an air ambulance service.

The HIMS also offered new experience for civil servants as part of a successful organisation to which they could make a personal contribution. Those who administered the HIMS found opportunities for exercising management skills in addition to their usual duties of regulation. They 'built up by flexible central

¹⁶² Pater, *op.cit.*, p. 10.

¹⁶³ A regular grant was made by the Department of Health for Scotland after 1929.

¹⁶⁴ T. C. Mackenzie, *The Story of a Scottish Voluntary Hospital* (Inverness, 1946), p. 225.

administration a system of co-operative effort, embracing the central department, private general practitioners, nursing associations, voluntary hospitals, specialists, local authorities and others to meet the medical need of the people.¹⁶⁵ It was to Scotland's great benefit that this 'system of co-operative effort' was carried over in the administration of the NHS in Scotland.

An Introduction to a Comprehensive State Medical Service.

The experience of the HIMS gave a clear indication of how a comprehensive state medical service would be received. Some of the uncertainties about the response of the public to a free service that caused concern to the administration during the planning of the National Health Service could have been resolved. The experience of the HIMS showed that while a free comprehensive medical service proved to be popular, it had not been excessively abused by frivolous demands. The Cathcart Committee had found that the crofters' families made fewer demands of the HIMS than those workers entitled to services under the National Health Insurance Scheme.¹⁶⁶ On the other hand, any idea that "illness," as perceived by the patients, could be reduced by the provision of curative medical care, and its cost therefore diminished, was, in time, shown to be illusory. In the experience of the HIMS, access to free modern medical services led to a rational, but nevertheless greatly increased, demand irrespective of any measurable improvement in the health of the population it served. It was shown that as additional funding became available it would be drawn towards the development of new and more sophisticated services that would, in turn, further increase demand and create more expense. The initial annual grant for the HIMS in 1913 was £42,000. In 1918 the Highland and Islands Fund had a balance of £134,027; in 1929 the balance had fallen to £32,538; by 1939 annual expenditure had risen to £89,692 3s 3d; by 1934 the balance (£3-15s-3d) had all but

¹⁶⁵ Cathcart Report, p. 232.

¹⁶⁶ Ibid., p. 227.

disappeared and demands on central funding had increased and would inevitably continue to increase. As has been shown this increase in expenditure did not have a commensurate effect in improving health. Health was more effectively improved by investment in the living conditions of the mass of the population. In the early decades of the twentieth century the greatest improvement in health was enjoyed by that part of the Scottish population relieved from the appalling consequences of life in the industrialised centres. Although the HIMS failed to have measurable effect on the health statistics of the population it served it had a great effect on its sense of well-being. At the beginning of the century the population of the Highland and Islands, like other sections of the population of Britain, looked for a service to meet their health needs, as they perceived them. It was in meeting the anxieties of people rather than in improving the public health, that the Highlands and Islands Medical Services was so successful.

The HIMS was the only experience in the United Kingdom of a demand led comprehensive service before the introduction of the NHS but a number of its important lessons passed unnoticed in the formulation of the legislation for National Health Service. In part it may have been that the geographic remoteness and economic circumstances of the Crofting Counties were assumed to make the experience of the HIMS irrelevant in the wider social context of an industrial United Kingdom. However the essential reason was that the HIMS had been established by, and continued to depend on, consensus, a spirit that had not been nurtured in London in the 1920s and 1930s while successive governments procrastinated in the founding of a national health service. It was still conspicuously absent when urgent planning for a National Health Service became necessary after the publication of the Beveridge Report in 1942.

But the experience was not lost in Scotland. The history of the Highlands and Islands Medical Service served to guide and encourage those to whom it fell to make

the National Health Service work in Scotland. By 1942 the doctors, the civil servants, the local authorities, the voluntary hospitals, the universities - all the chief begetters of Scotland's National Health Service - had already learned to work together. And by July 1948 the population of Scotland had already been introduced to the concept of a free comprehensive medical service provided by the state.

CHAPTER TWO

COLLINS, CATHCART AND THE DISTANCE FROM LONDON

Sir Godfrey Collins and Professor E. P. Cathcart personified the influences that separated the medical services of Scotland from those of England and Wales in the 1930s. Sir Godfrey Collins, Secretary of State for Scotland and an advocate of devolution of the administration of government, appointed a committee to review the health services of Scotland, a review that had no counterpart in England and Wales. Professor Cathcart, who chaired that committee, typified the leadership of the medical profession in Scotland, a profession with traditions and an approach to the practice of medicine quite different from the medical profession in England and Wales.

Collins and the Political Will.

On introducing the National Health Service (Scotland) Bill for its Second Reading on 10 December 1946, the Secretary of State for Scotland, Joseph Westwood, stressed that his was a Scottish Bill and that he would keep it as a Scottish Bill. Its details would be ‘threshed out’¹ in debate within the Scottish Grand Committee. Although he acknowledged that over many months there had been ‘many interesting and valuable discussions...on the English Measure’,² he made it clear his Bill was nevertheless still based on the recommendations made by the Scottish Health Services Committee (Cathcart Committee) in 1936 and on the thirty three years of practical experience of the administration of the comprehensive Highlands and Islands Medical Service. In presenting his Bill, Westwood quoted frequently and at length from the *Report of the Scottish Health Services Committee*³ of which he himself had ‘had the honour and privilege to be a member.’⁴

¹ *Hansard*, xlxxxi, HC 10 December 1946, col. 1002.

² *Ibid*, col. 1001.

³ Cathcart Report.

⁴ *Hansard*, xlxxi, op. cit., col. 996.

The Committee had been appointed in June 1933 when Britain had not yet recovered from the Depression, and its industrial communities still suffered massive unemployment, poverty, malnutrition and disease. But it was Britain's fiscal problems rather than the particular urgency and severity of the health problems in Scotland that had caused the appointment of a committee to review Scotland's health services. The brief post-war boom had come to an end in the early 1920s and the downturn in world trade had soon led to recession in industry in Britain and deepening problems in the country's balance of payments. In 1929 the Wall Street Crash caused an international slump, exacerbating Britain's troubles. National income could not support existing commitments. A third of government spending was already taken up in repaying charges on debts accumulated during the First World War. In itself this was an enormous problem but it was made worse by the spiralling cost of supporting the increasing numbers of the unemployed. By January 1931 government deficit had almost doubled since 1928; the United Kingdom was in financial crisis. The Labour Government, having failed to find a formula to meet the crisis, was replaced by a National Government in August. The emergency budget devised by Snowden, the Labour Chancellor, in September again failed to improve matters. Following the election of 5 November, Snowden was replaced as Chancellor of the Exchequer by the Conservative Neville Chamberlain.

Among the possible strategies for recovery, Chamberlain gave first priority to protection behind a barrier of tariffs in an attempt to reduce the adverse balance of trade. But there was also to be a rigorous tightening of the belt at home. Chamberlain looked for a reduction in public expenditure. He wrote to the local authorities both in England and Wales and in Scotland, requiring them to form committees to 'consider the whole field of local expenditure and make recommendations at the earliest possible date for securing reduction in such expenditure whether defrayed by Exchequer Grant, Rates or other sources, whether or not imposed on local authorities

as a duty by statute, order or regulation.’⁵ A time limit of three months was set for their replies.

Two separate committees - for England and Wales and for Scotland - were formed as directed but neither was able to find answers as quickly as the Chancellor had demanded. Finally in November 1932 the committees produced two very different documents. The Report of the Committee on Local Government Expenditure in England and Wales, after careful review of spending on the various local authority services, indicated possible scope for economy only in very general terms and set no financial targets. On spending on health this committee recommended only that:

1. There should be an immediate inquiry into building costs of institutions and when suitable standards had been determined action should be taken to secure that they are observed.
2. Careful consideration should be given to the feasibility of establishing standards of maintenance costs.
3. Institutional treatment should be reserved for cases that cannot adequately be treated otherwise.
4. Large economies could be secured in expenditure on hospital supplies by simplifying and standardising the articles required and by central purchasing.
5. Persons able to pay should be required, as a rule, to contribute to the costs of the service provided for them.
6. Comparative statements of costs are of real value but the function of the Ministry of Health should not be limited to collecting and publishing them.⁶

The responsible minister in England and Wales,⁷ Sir Hilton Young, the Conservative Minister of Health, took no action in response to these recommendations.

⁵ *Report of the Committee on Local Expenditure (Scotland)* (Lovat Report), 1932, Cmd. 4201, p.1.

⁶ *Report of the Committee on Local Expenditure (England and Wales)* 1932, Cmd. 4200.

⁷ At that time the Ministry of Health was responsible for all local government.

In Scotland the response to the Chancellor's directive was quite different. The Committee in Scotland was formed by three representatives each from the Association of County Councils of Scotland, The Royal Burghs of Scotland, and the Association of the Counties of Cities, with Lord Lovat as Chairman.⁸ This committee (Lovat Committee) examined the public services in detail, making specific recommendations and setting financial targets for each one. On education the Committee identified possible savings of £950,000 with a further reduction on yearly capital commitments of £500,000; on roads annual savings of £1,250,000 were recommended and on police services annual savings of £250,000. On housing £153,500 could be saved (£117,000 accruing to the Exchequer and £36,500 to the ratepayers). From Public Assistance savings of £400,000 were possible and on administration, £529,800 (£527,000 accruing to the ratepayers and £2,800 to the Exchequer).⁹

On spending on health the Lovat Committee reached a decision very different from the very broad and accommodating suggestions made by the Committee for England and Wales. After the most careful scrutiny the Scottish committee was forced to conclude that 'no real savings can be achieved in relation to health services until they are submitted to a comprehensive enquiry that would take into account modern medical knowledge and the prevailing financial condition.'¹⁰ The Committee endorsed and quoted the views of one Medical Officer of Health:

The health policy of the nation has never been completely reviewed since the latter half of the last century- over 50 years ago¹¹ - and since then statutory health services have branched out in many different directions. No attempt has been made to relate these diverse activities to a clear purpose. And it is the absence of the clear purpose and the

⁸ Lord Lovat, KT, DSO (Inverness-shire); Ian Carmichael, DSO, MC, MA (Lanarkshire); J.M. Hodge (Perthshire); Sir Henry Leith, LLD, JP (Hamilton); Provost J. R. Rutherford, JP, FICS (Kirkintilloch); Provost Henry Smith (Kilmarnock); Treasurer L.S. Gumley (Edinburgh); Treasurer M. Lunan (Aberdeen); Treasurer G.D. Morton (Glasgow).

⁹ Lovat Report.

¹⁰ Ibid., p. 97.

¹¹ A reference to the review preceding the Scottish Local Government Act of 1889.

failure to correlate all health activities to serve it that is at the root of the tragic lag between established knowledge and its application in promoting fitness.¹²

The Lovat Committee had found no opportunities for the reduction in the range of local authority health services that would lead to worthwhile economies. But their investigation had revealed inefficiencies in the organisation and administration of the existing services with much overlapping of responsibilities and waste of resources. The Committee therefore recommended that 'an independent enquiry into the whole subject of Public Health from every standpoint - health, social and financial - be at once instituted.'¹³ The Lovat Report was presented to the House of Commons in November 1932 by Sir Godfrey Collins, the recently appointed Secretary of State for Scotland. Within a few months he had appointed the Committee on Scottish Health Services.¹⁴

Collins had been in office for only two months when he received the report of the Lovat Committee.¹⁵ For the future development of health services designed specifically for Scotland, his was a singularly fortunate appointment. His term of four years as Secretary of State for Scotland was a brief Indian Summer for the New Liberalism that had influenced political thinking in the early years of the century. Sir John Simon recorded the great delight of the Liberals in the Commons that, in 1932, Collins' opportunity had come at last.¹⁶ Collins grasped his opportunity and at once embarked on a program of social reform for Scotland. By an accident of timing, the

¹² Lovat Report, p. 96.

¹³ Ibid.

¹⁴ Honigsbaum has wrongly asserted that the Cathcart Committee was set up to reconcile divergent medical interests in Scotland in order to meet the needs of the unemployed, particularly after 200,000 had exhausted their rights to medical care under the NHI scheme in 1932. F. Honigsbaum, *The Struggle for the Ministry of Health* (London, 1970), p. 10.

¹⁵ Sir Arthur Sinclair had been Secretary of State for Scotland in the National Government since August 1931 but was unable to accept its tariff policy. He resigned from the Government in September 1932.

¹⁶ *The Times*, 14 October 1936.

Lovat Committee's recommendation for an inquiry into Scotland's health services became caught up in Collins' overall program for Scotland.

Collins had been attracted to national politics in 1910¹⁷ by the social reforms which Asquith and Lloyd George were then carrying through Parliament.¹⁸ His support for social reform was in keeping with his family tradition. Through several generations the family had been active in philanthropy, in the temperance movement and in local government.¹⁹ The family publishing house, of which Collins was then the very successful managing director,²⁰ had been established by his great-grand father to publish the sermons of his close friend the evangelical reformer Dr Thomas Chalmers. Later generations of the family promoted their company to become the only publisher of Bibles and the principal publisher of educational material in Scotland.

Collins was already well known in the West of Scotland for his advocacy of New Liberalism when he was asked to stand for Parliament as a Liberal in 1910. From his first election until his death in 1936 he represented Greenock, a town which, in its poverty, ill health and slum housing, was among the worst in Scotland. His constituency was part of Red Clydeside, where, especially in the years of the First World War there was considerable unrest due to 'a convergence of Marxist political theory with industrial fact.'²¹ Collins was a conscientious Member of Parliament, seen always to be active in the interests of the deprived in his constituency. He was a popular and effective campaigner in the backcourts and greens of Greenock. In seven

¹⁷ M. McCrae, *Dictionary of National Biography*, in press. Sir Godfrey Collins has no biography. He is not mentioned by Sir John Brotherston in 'The Development of Public medical Care' in G. McLachlan, *Improving the Common Weal* (Edinburgh, 1987) nor is he acknowledged in any of the histories of the NHS.

¹⁸ G. Pottinger, *The Secretaries of State for Scotland*, (Edinburgh, 1979), p. 61.

¹⁹ His grandfather, Sir William Collins, was Lord Provost of Glasgow.

²⁰ Collins had expanded the company's list. He launched the *Collins Illustrated Pocket Classics*, *The Nation's Library*, and *The Sevenpennies*. He published H.G. Wells, Rose Macauley and Walter de la Mere. He introduced Agatha Christie, Dorothy Sayers, Ngaio Marsh as authors of his series, 'Crime Club'. His final venture as a publisher was to produce the 'Westerns' so much enjoyed by Lloyd George.

²¹ C. Harvie, op.cit., p. 16.

general elections he retained a comfortable majority against strong opposition from Communist and Labour candidates. Throughout his long parliamentary career he served a working class constituency that shared in full all the social ills of the 1920s and 1930s. In his last election in 1935, shortly before his death, he had his highest ever majority.²²

Within months of his arrival in the House of Commons in 1910, Collins had been appointed as a Parliamentary Private Secretary to the Secretary of State for War. As a young man he had served in the Royal Navy; on the outbreak of the First World War he volunteered for service in the army and served with distinction in Gallipoli and in Mesopotamia.²³ On his return to the House of Commons he was made a Junior Lord of the Treasury in 1919 but in office he soon became disheartened and disillusioned by the Government's failure to secure the strict control of public expenditure that he believed to be essential. In the end, it was his refusal to accept government policy for Ireland that led to his resignation in 1920.²⁴ In 1921 he crossed from the government side of the House to join the Asquith Liberals. Now openly in opposition, he was free to speak against Government policy on reparations, believing that they would destabilise Germany and eventually lead to war. On home affairs he argued that a continuing excess of government bureaucracy would inhibit the recovery of the country's economy. For almost all of his remaining years in Parliament he had remained excluded from any position of influence.²⁵ When he was suddenly and unexpectedly invited to become Secretary of State for Scotland he

²² It had been widely expected, and forecast in the press, that as a Liberal National, he would lose his seat in an election in which a large Conservative majority was expected and Liberals of all groups seemed almost irrelevant.

²³ First made CMG and knighted in 1919.

²⁴ Many of the Liberals who had supported Lloyd George were also alienated.

²⁵ McCrae, *op. cit.*

received the invitation with 'utter amazement.'²⁶ But he was more than ready to accept the appointment.²⁷

From the beginning he made it clear that his objective as Secretary of State for Scotland, was to reduce Scotland's material deprivation in all its forms. His cause was, as always, essentially humanitarian but in 1932 he had an additional motive. By improving social conditions he hoped to dampen the rising spirit of nationalism and silence the crescendo of calls for Home Rule. Within weeks of his appointment he wrote to the Chancellor of the Exchequer:

I think you are aware that in recent months the agitation in certain quarters for a measure of Home Rule for Scotland has assumed considerable proportions. My opinion is that the ranks of the supporters of the movement at the present time are greatly swelled by the prevalence of a belief that Scotland is not obtaining a fair return for her contribution to the national revenue.²⁸

In the years until his death in office Collins set about securing that 'fair return' for Scotland by laying the foundations for improvements in the economy, in housing and, not least, in health.

To ensure the effective management of his schemes for Scotland he at once proceeded to devolve the relevant administrative authorities from London to Scotland. Having been a believer in reduced government in 1920 he had become a convert to a new faith in 1932. He set about creating a commanding centralised, but devolved, Scottish administration. First, he began a reorganisation of the Scottish Office. A substantial part of its work was transferred from Dover House in London to various departmental offices sited in Edinburgh. On 15 February 1934 he opened the Edinburgh Branch Office of the Scottish Office as a temporary head quarters until a new building could be built on Calton Hill to house all the Scottish Departments

²⁶ Pottinger, *op.cit.*, p. 54.

²⁷ Collins was appointed following the resignation of Sir Archibald Sinclair (Lib.) presumably to increase the representation of Liberal Nationals in the National Government.

²⁸ NAS HH 1/791.

together on one site. At the opening of the Branch Office, he announced his intention to set up a Committee²⁹ to 'inquire into and report upon the responsibilities and organisation of the Scottish administrative Departments under the control of the Secretary of State, the distribution of duties amongst these Departments, their relationship to the central executive Government, and the arrangements under which liaison is maintained between Edinburgh and the central executive government.'³⁰ The Department of Health for Scotland, which had previously conducted its business in Edinburgh with little or no reference to the Scottish Office in London, became part of a new integrated Office of the Secretary of State for Scotland.³¹ This office was established in Edinburgh as a confederation of the four large Departments – Home Department, Department of Health, Department of Agriculture and Fisheries and Department of Education. As a result of Collins' initiative the Department of Health for Scotland, with its responsibility for housing as well as health, was made part of a devolved administration in Edinburgh, answerable only to the Secretary of State for Scotland and not to the Minister of Health in London

In 1918 Collins had complained of the inadequacies of the staff of the Scottish Office.³² In office as Secretary of State he set out to find 'officers of suitable quality, education and otherwise'³³ to replace the civil servants of executive grade who had previously made up the staff of the Scottish Office. In 1935 he obtained Treasury approval to recruit administrative-class officers into the Department of Health. Among the first to be recruited, through Class I open competition, was T.D.(later Sir Douglas) Haddow.³⁴ He and the other able and ambitious civil servants who came

²⁹ This committee was still at work at the time of Collins' death in June 1936.

³⁰ NAS HH 45/61.

³¹ 'The clean method of overcoming difficulties is to make one fold, as there is one shepherd, by a general transfer the power and the duties of Departments to the Secretary of State.' Memorandum by the Assistant Secretary, the Scottish Office, 17 November 1932. NAS HH 1/799.

³² *Hansard*, cvii, HC 4 July 1918, col. 1974.

³³ Sir G. Collins quoted by I. Levitt, *The Scottish Office* (Edinburgh, 1992), p.16.

³⁴ Sir Douglas Haddow's papers have kindly been made available by his son.

together in the Department of Health were later to play a vital role in the establishment of the National Health Service in Scotland.

Having begun the reorganisation of the Scottish Office, Collins increased its powers to influence the Scottish economy. Under the Special Areas (Development and Improvements) Act of 1934 schemes were designed to aid the recovery of those parts of the United Kingdom that had been most severely affected by the Depression. Although one of these distressed areas was centred on Lanarkshire, in the original drafting of the Bill it had been intended that there should be only one Commissioner for all the Special Areas in the United Kingdom who would answer to the Minister of Labour. Collins persuaded Chamberlain that this would not be acceptable to public opinion in Scotland. Cabinet reluctantly agreed that there should be a separate Scottish Commissioner within the jurisdiction of the Scottish Office with a budget twice the 'Goshen formula'.³⁵ This new capability for the promotion of industry was the beginning of a new economic development function for the Scottish Office.³⁶ Before his death Collins had sanctioned the formation of the Scottish Economic Committee that was to be developed by his successor as Secretary of State, Walter Elliot.

Collins also acquired additional powers for the Scottish Office to cope with Scotland's long standing problems in housing. For more than a century it had been widely recognised that housing conditions in Scotland were worse than in England and worse than in most other parts of Europe. But it was the report of the Royal Commission on Scottish Housing³⁷ in 1917 that had revealed the full appalling extent of the problem. The Royal Commission recommended that the state must accept direct responsibility for the housing of the working class. In 1919 the National Government announced its intention to promote house building as part of post war

³⁵ A calculation made in 1888 that Scotland was entitled to share in grants in the ratio of 11 parts to England's 80 as recognition of her share of taxation.

³⁶ J.S. Gibson, *The Thistle and the Crown: A History of the Scottish Office*, (Edinburgh, 1985), p. 78.

³⁷ *Report of the Royal Commission on the Housing of the Industrial Population of Scotland Rural and Urban*, 1917, Cd. 8731.

reconstruction, building 'homes for heroes.' In the 1920s and into the 1930s, housing in the United Kingdom remained high on the agendas of successive governments. But, as had been admitted in 1917, there were particular problems in Scotland

Successive Scottish Secretaries before Collins had argued in Cabinet for special consideration for Scotland's greater needs but with no success. In 1920 Robert Munro had been unable to prevent the suspension of the Scottish building programme. His successor, Lord Novar, had failed to persuade Neville Chamberlain, the Minister of Health, that Scotland's housing problems justified special treatment in his Housing Act of 1923. John Wheatley, as Minister of Health in the Labour government, though himself an MP for a Clydeside constituency, had made little concession to Scotland's special problems in his Housing (Financial Provisions) Act of 1924. In 1925 Walter Elliot, as Parliamentary Under Secretary of State at the Scottish Office in the succeeding Conservative government, made an ingenious attempt to win concessions for Scotland. He out-manoeuvred the denial of special aid for Scotland by the Minister of Health, Neville Chamberlain, by inviting the Prime Minister, Stanley Baldwin, to visit the slums of the Gorbals³⁸ and Cowcaddens. Following his visit Baldwin announced a subsidy of £40 per house to Scottish local authorities for the erection of steel prefabricated houses. The manoeuvre backfired; the steel houses found no favour with the local authorities and Chamberlain announced that in future he would be extremely watchful that the Scottish Office got no more out of Government than its fair share.³⁹ Sir John Gilmour, as Secretary of State, continued to maintain that the British housing policy 'barely touched the fringe'⁴⁰ of the problems in Scotland but, either in spite of or because of his Under Secretary's activities, no concessions were forthcoming. By 1932 the gap between Scotland and England in the supply of houses had widened further than ever. With interest rates and other costs

³⁸ Walter Elliot had personal experience of the Gorbals as a medical student and while working on nutritional problems with Professor Cathcart in the Department of Physiology of Glasgow University. He continued his research work at the Rowett Institute and was awarded a DSc.

³⁹ Gibson, *op.cit.*, p. 71.

⁴⁰ Quoted by Levitt, *op. cit.*, p. 43.

falling, England was beginning to enjoy a housing boom that was not matched in Scotland. Sir Hilton Young, the Minister of Health, felt justified in withdrawing housing subsidies except for those aimed specifically at slum clearance. It was now that Collins won the first real concession for Scotland; the general subsidy was retained in Scotland and Collins went on to consolidate this success. In 1934, when the cabinet agreed that the Housing Bill for England should make provision of a basic subsidy of £3 for each house for twenty years, Collins successfully argued that considerable modification of this scheme would be required for Scotland. The Housing (Scotland) Act 1934 negotiated by Collins allowed for a basic subsidy of £6.15.0 for forty years with an additional £4 per house in areas where extensive redevelopment was required.⁴¹

Collins was equally determined to pursue an independent line for Scotland in improving the state of the country's health. By increasing the strength and potential of the Department of Health for Scotland he had created a suitable instrument. The Lovat Committee had provided the occasion. While in England the responsible minister, the Conservative Sir Hilton Young, took no action in response to the recommendations of the Committee on Local Expenditure (England and Wales), Collins, the Liberal reformer in Scotland, seized on the recommendation of the Lovat Committee as the opportunity to improve all medical services in Scotland - including those for which his department was not yet responsible. In June 1933 Collins appointed the Committee on Scottish Health Services:

To review the existing health services of Scotland in the light of modern conditions and knowledge and to make recommendations on any changes in policy and organisation that may be considered necessary for the promotion of efficiency and economy.⁴²

⁴¹ Levitt, *op.cit.*, p. 272.

⁴² Cathcart Report, p. 3.

The Cathcart Committee

Collins brought together in the Committee on Scottish Health Services the best and widest spectrum of advice available. He did not invite the various public bodies in Scotland, state and voluntary, with responsibilities for providing health care to delegate one of their number to watch out for the interests of their own organisations. The records of the British Medical Association and the Royal Medical Corporations in Scotland show no evidence that the medical profession was formally consulted about the constitution of the Committee. Invitations to take part in the work of the Committee were made to individuals chosen as those most likely to be useful in shaping new health services for Scotland.

The Chairman chosen for the Committee was Sir John Dove Wilson, a senior servant of the Crown with experience of chairing such bodies.⁴³ Nicol McColl of the Administrative Section of the Department of Health was appointed as Secretary. Three senior officials of the Department of Health attended (J. Vallance, Assistant Secretary, James Brownlie, Chief Medical Officer, and John Jardine of the School Medical Service).

Although not formally represented by delegates, the principal organisations with an interest in the existing health services each found a voice from among the eighteen members of the Committee. There were voices from:

- a) Local Government - Provost David Fisher of Hawick, Sir Andrew Grierson, Treasurer of Edinburgh, and Violet Robertson, Convenor of Glasgow Corporation Health Committee.
- b) Insurance Committees - W.M. Marshall, Scottish Association of Insurance Committees.
- c) Trade Unions - Joseph Westwood, Political Organiser, Scottish Miners.
- d) Public Health - Alexander Macgregor President of the Royal Sanitary Society.

⁴³ Sir John Dove Wilson was a retired Judge President of the Natal Division of the Supreme Court of South Africa and currently Chairman of the Committee on Recurrent Offenders.

- e) British Medical Association - R.W. Craig, Scottish Secretary.
- f) Royal Medical Corporations - Alexander Miles, President of the Royal College of Surgeons of Edinburgh.
- g) University Medical Schools - E.P.Cathcart, Professor of Physiology, Glasgow University.
- h) Nursing - Mrs Chalmers Watson, Queen's Institute of Nursing.

Each Committee member was more than a voice from the body to which he belonged. Every member had already made a significant contribution to the improvement of public service. Following the precedent of the Scottish Board of Health in 1918, the Committee included women members. These were not token members.⁴⁴ Mrs A. M. Chalmers Watson MD, CBE,⁴⁵ the wife of the senior physician at Edinburgh Royal Infirmary had been the first woman medical graduate of Edinburgh University and was a recognised authority on nutrition. (She was later appointed to the Government's Advisory Committee on Diet.) She was President of the British Medical Women's Federation, editor of the *Encyclopaedia Medica* and a founder of the Edinburgh College of Domestic Science. In the First World War she had been the first Controller of the Women's Army Auxiliary Corps. At the time of her appointment she was Hon. Secretary of the Queen's District Nursing Association. Lady Mackenzie CBE was the wife of Sir Leslie Mackenzie, who as the first Medical Inspector of the Local Government Board for Scotland, had been prominent in public health reform since his researches for the Royal Commission on Physical Training in 1903; Lady Mackenzie had been her husband's assistant in his researches. When appointed to the Committee

⁴⁴ In spite of their achievements, while their husbands are listed in *Who's Who*, the women themselves are not.

⁴⁵ Mrs Mona Chalmers Watson, the first woman medical graduate of Edinburgh, was a member of a distinguished family. Her brothers Sir Eric Geddes and Sir Auckland Geddes had both been members of the Cabinet in the Coalition Government 1916-1922. Elizabeth Garret Anderson, the first English women medical graduate, was a cousin.

she was Director of the Edinburgh College of Domestic Science and author of several works on child welfare, special schools and mental deficiency. Baillie Violet Robertson CBE was a graduate of Queen Margaret College, Glasgow and the University of Dresden. For many years she had been Convenor of Glasgow Corporation Health Committee, the first woman in Britain to hold such a post. (After the Second World War she was to be awarded the St Mungo Prize for her work in child health.)

Of the men, R. W. Craig had played a prominent part in drawing up the BMA's proposals for reform in its pamphlet *A General Medical Service for the Nation* published in 1930.⁴⁶ Ian Carmichael DSO, MC, Convenor of Lanarkshire County Council, had been a leading member of the Lovat Committee that had first recommended that health services in Scotland should be reviewed. David Fisher was a member of the Empire Marketing Board that had initiated John Boyd Orr's famous trial of the nutritional value of milk in 1926.⁴⁷ Alexander Gray, Professor of Political Economy at Aberdeen University, was a former member of the Royal Commission on National Insurance and Chairman of the Consultative Council on National Health Insurance. Sir Andrew Grierson, Town Clerk of Edinburgh had, for several years, been an outspoken advocate of administrative reform by extension of local government. Alexander (later Sir Alexander) Macgregor, as Medical Officer of Health for Glasgow, had established a reputation by making maximum use of the existing enabling legislation to expand the local authority health services in Glasgow further than had been attempted by any other authority in Scotland. Alexander Miles, was editor of the *Edinburgh Journal of Medicine*, a member of the General Medical Council and a Curator of Patronage of the University of Edinburgh. Joseph Westwood had been briefly Under-Secretary of State for Scotland in 1931 and was

⁴⁶ *BMJ*, i, 1930, p.165.

⁴⁷ Sir Leslie Mackenzie was chairman of the Empire Marketing Board; Tom Johnston, Secretary of State during the wartime planning of the NHS, was also a member. Its successor, the Milk Marketing Board, was set up in 1933 by Boyd Orr's friend and Collins' successor as Secretary of State, Walter Elliot.

later to be the Secretary of State at the time of the National Health Service (Scotland) Act in 1947.

During his few years of political influence before his death in 1936, Sir Godfrey Collins was determined that social condition in Scotland must be improved and convinced that improvement could best be achieved by a devolved administration. In the Department of Health for Scotland he created a devolved bureaucracy to administer health services separately in Scotland. In the Cathcart Committee he created an authoritative body to advise on how these services should be shaped.

Cathcart and Medical Leadership.

The dominant personality on the Committee, and the inevitable choice as its chairman on the death of Sir John Dove-Wilson in April 1935, was Professor Edward Cathcart. His background, his career and his philosophy made him an outstanding leader of the medical profession in Scotland and an appropriate choice as a guide in the planning of future health services for Scotland. That he should represent the leadership of the medical profession in Scotland provides an insight into the nature of the differences between the Scottish medical tradition and the tradition in England, a gulf that was to complicate the creation of a National Health Service in the United Kingdom.

Cathcart qualified in medicine in Glasgow in 1900 intending to make his career in clinical medicine. It was then usual in Scotland for ambitious clinicians to complete their training in Germany or in one of the other great continental centres of medical science.⁴⁸ Cathcart went first to Berlin and then to Munich for post-graduate experience in the clinically useful science of bacteriology. It was a chance meeting with the physiologist, Karl Voit, in Munich that diverted his interest from bacteriology to the new science of nutrition and diverted him from a career as a

⁴⁸ After the war the link with Germany was lost. Before the Second World War the United States had already begun to take Germany's place in postgraduate training in medicine.

clinician with special interest in bacteriology to a career as a medical scientist with close links to clinical practice.

Germany was then at the forefront of medical science. In the reconstruction of Germany after the Napoleonic Wars the universities had been become state institutions instructed 'to redirect the emphasis from pedagogy and encyclopaedic learning to independent research'.⁴⁹ The states were intent on producing graduates ready to tackle the problems of the industrialising economy of Germany in the middle of the nineteenth century. Almost every university in Germany established new research institutes to produce work in the interest of the state. Germany became perhaps the foremost centre of scientific research in the nineteenth century.⁵⁰

The medical sciences were of particular interest to the state. While it was accepted that the state has a duty to promote the well being of the citizen it was also accepted that the citizen had a duty to the state to maintain his fitness for labour in industry and for service in war⁵¹ and fitness required an adequate diet.

Karl Voit, Cathcart's mentor, having established his reputation by developing quantitative methods for determining the food requirements for the maintenance of a 'normal' life, was required by the state to use these methods in advising on the control of food intake in such institutions as prisons and workhouses and in the military services.⁵² Employers in German industry were also interested in sound nutrition with a view to securing the fitness and efficiency of their workers.⁵³ Their interest was expressed by *Kölnische Zeitung*:

To create, maintain and support industrious workers, that is the unavoidable requirement for the future of industry. Countries such as England, France and Belgium owe their superiority in certain branches of industry partly to the greater productivity of their workers. We must

⁴⁹ A. M. Tuchman, *Science, Medicine and the State in Germany* (Oxford, 1993), p. 5.

⁵⁰ *Ibid.*, p. 4.

⁵¹ H. Kamminga and A. Cunningham (eds.), *The Science and Culture of Nutrition, 1840-1940* (London, 1995), p. 2.

⁵² D. Milles, 'Working Capacity and Caloric Consumption: The History of Rational Physical Economy', in Kamminga and Cunningham, *op.cit.* p. 78.

⁵³ *Ibid.*

endeavour to grant the worker all he needs for his and his dependants' subsistence.⁵⁴

It was in this context that Cathcart was introduced to the study of nutrition in Munich. His later work derived from this training and experience. His nutritional research was on food as a source of energy and on the design of diets to maximise human capacity for work. (Cathcart eventually published his corpus of work in 1929 in his book *The Human Factor in Industry*.).

After working for a time with Francis Benedict⁵⁵ in the United States, Cathcart returned to Britain in 1915 as Professor of Physiology at the London Hospital. He was quickly recruited into the Royal Army Medical Corps, to investigate the energy requirements of army recruits and later to advise on the dietary requirement of soldiers in the field. Cathcart continued to be consulted by government after the war and his return to Glasgow as Professor of Physiological Chemistry at Glasgow University. As the *BMJ* later said of him, 'few men can have served on so many expert committees.'⁵⁶ He was at some time a member of the Medical Research Council, the League of Nations Technical Advisory Committee on Nutrition, the Army Hygiene Advisory Committee, the National Advisory Committee on Physical Training (Scotland), the Ministry of Health's Advisory Committee on Nutrition, the Committee on Nutrition in the Colonial Empire, the International Labour Office's Committee on Industrial Hygiene and Chairman of the Industrial Health Research Board. His experience as an established adviser to governments and his eminence as a medical scientist made him an obvious choice to serve on the Committee on Scottish Health Services. As an eminent advocate of the principle that medical practice and medical science were inseparable, Cathcart was respected by members of every branch of the medical profession in Scotland. That he had held a university chair for

⁵⁴ *Kolnische Zeitung*, 29 December 1880, quoted *ibid.* p. 78.

⁵⁵ Benedict, a Harvard graduate, had completed his training at Heidelberg.

⁵⁶ *BMJ*, i, 1954, p. 532.

twenty years established his authority in Scotland where the medical profession traditionally looked to the universities for leadership.

The medical profession in England did not draw its leaders from the universities. In England and Wales the leaders of the profession belonged to a body of elite clinicians who kept medical science and the medical scientists of the universities at a careful distance. In the 1930s Lord Horder, royal physician and physician to St Bartholomew's Hospital, London, was perhaps the most prominent member of that elite. In 1936, Lord Horder was invited to give the opening lecture of the Bicentenary Session of the Royal Medical Society in Edinburgh.⁵⁷ He was at pains to make it clear to his audience of Scottish medical students that he was not of 'the tradition in your country.'⁵⁸ While he expressed his respect for the tradition of Cullen, Syme, Lister, Bright, Addison and Simpson he was proud to belong to another, English, tradition. This, Horder held to be the tradition of Hippocrates, realised in England by the great William Harvey, Thomas Sydenham, Edward Jenner and Samuel Gee. In the early years of the twentieth century (while Edward Cathcart was completing his training in physiology in Munich), Samuel Gee, Horder's mentor at St Bartholomew's, was instructing his students: 'When you enter my wards your first duty is to forget all your physiology. Physiology is an experimental science and very good thing in its proper place. Medicine is not a science but an empirical art.'⁵⁹ In the English tradition the ideal physician was a gentleman scholar, devoted to literature and natural history, caring conscientiously and empirically for his patients in patrician style with his mind uncluttered by scientific theory.⁶⁰ In the English tradition, as Horder informed his student audience in 1936, the personality, personal experience

⁵⁷ Published later in Lord Horder, *Health and a Day* (London, 1937), p. 42.

⁵⁸ *Ibid.*, p. 43.

⁵⁹ Sir Henry Dale, *BMJ*, ii, 1950, p. 1187.

⁶⁰ Christopher Lawrence has set out an excellent critique of the English tradition in 'Ornate Physicians and Learned Artisans' in W. F. Bynum and R. Porter (eds.), *William Hunter and the Eighteenth Century Medical World* (Cambridge, 1985), and in his unpublished lecture 'Edward Jenner's Jockey Boots and the Great English Tradition in Medicine' given to the Society for the Social History of Medicine in Glasgow in July 1999.

and 'horse sense' of the doctor were the fundamental elements in the management of patients. The study of medicine was to be regarded as an extension of natural history rather than of experimental science. Clinicians were advised to be cautious of 'laboratory methods and the exploitation of instruments of precision.'⁶¹ While the information provided might add to his careful observation of the patient, Horder denied that the physician's work required the sanction of science. The practice of medicine must be inductive and empirical.

By the beginning of the twentieth century an English medical elite in this tradition had become institutionalised in the London teaching hospitals, in Harley Street, at the Royal College of Physicians of London and the Royal College of Surgeons of England.⁶² The position of the Colleges was challenged in 1815 when a licence from Apothecaries' Hall became recognised as the essential qualification for general practitioners in England. Faced by this competition, in 1860 the Royal College of Physicians extended its area of jurisdiction beyond London, granting licences to practice elsewhere in England and Wales. However many public appointments now required a qualification in both medicine and surgery; in 1884 the Royal College of Physicians London and the Royal College of Surgeons formed a Joint Board examining for a combined qualification⁶³ 'to prevent candidates from crossing the border to Scotland.'⁶⁴

At that time the only universities granting degrees in medicine in England were Oxford, Cambridge and Durham. 'By 1890 to these had been added the complex of colleges and medical schools comprising the Victoria University centred on Manchester'⁶⁵ and by the early years of the new century the provincial universities all granted degrees in their own right. Nevertheless large numbers of those intending to make their careers in general practice across England and Wales continued to take

⁶¹ Ibid., p. 48.

⁶² The evolution of this elite is discussed in Chapter Eight.

⁶³ MRCS LRCP.

⁶⁴ C. Newman, *The Evolution of Medical Education in the Nineteenth Century* (London, 1957), p. 298.

⁶⁵ Ibid., p. 292.

only the qualifying examination of the Joint Board.⁶⁶ Even as medical education expanded, London continued to be the head and heart of the English system and its patrician clinicians remained in charge.

In the 1930s, in essentials, nothing had changed. Graduates of Oxford and Cambridge still dominated the Fellowship of the Royal College's in London and the clinicians to the English teaching hospitals were without exception Fellows of the College.⁶⁷ In the 1930s this elite, practising privately among the wealthy and adopting the life style and leisure activities of their plutocratic patients,⁶⁸ dominated the medical profession in England and set the style of practice. (It was their commitment to the empiric clinical individualism that later, during the struggles for the National Health Service, was to be disguised as 'clinical freedom' and claimed as a right for the whole medical profession.) In London the patrician doctors, practising, and to some extent living, in the society of the most wealthy, aristocratic, and influential in the country, made up the most powerful medical interest in Britain in the 1930s.⁶⁹

In Scotland there was no counterpart of the London entrepreneurial medical elite nor was there a society in Scotland that could have supported such an elite. The transfer, first of the Crown and later of Parliament had drawn generations of the aristocracy, the wealthy and the politically powerful to London.⁷⁰ Medicine and the

⁶⁶ The examinations of the Joint Board were thought to be easier than those of the universities. Many students took the MRCP LRCP as a bird in the hand.

⁶⁷ When James Williamson was appointed in 1960 as Professor of Geriatrics at Liverpool with charge of wards at one of the city's teaching hospitals he was initially excluded from the hospital's Medical Committee on the grounds that, although he was a Fellow of the Edinburgh College he was not a Fellow of the Royal College of Physicians of London. Personal communication.

⁶⁸ Bertrand (later Lord) Dawson found it necessary to have dancing lesions before becoming physician to Edward VII. (F. Watson, *Dawson of Penn* (London, 1950), p. 35); Sir Stanley Woodward's large Kent estate was known to his students as Bedside Manor; Lord Horder also had a large country estate, many servants and a passion for Rolls-Royce cars. (M Horder, *The Little Genius* (London, 1966), p. 66.)

⁶⁹ They exerted their influence quietly. Since the activities of the BMA were noisier and better documented, historians have tended to exaggerate its relative importance.

⁷⁰ N.T. Philipson, 'Nationalism and Ideology' in J.N. Wolfe (ed.) *Government and Nationalism in Scotland* (Edinburgh, 1969), p. 170.

other distinctively Scottish institutions of civil society, the church, the parish schools, the law, and the universities, had survived the Union. Over two centuries the medical profession had flourished but had not developed a hierarchical structure as in England where the structure of the medical profession reflected the structure of the hierarchical society it aimed to serve. In Scotland, trained with different objectives the medical profession developed in close association with the universities.

From the beginning of the eighteenth century, and in contrast to the free-for-all of the London teaching hospitals where training was by conducted by individual clinicians,⁷¹ the Scottish university medical schools had a set curriculum and teaching was firmly under the control of the professors. While the practice of medicine was acknowledged to be an art, that art was based on the systematic study of natural philosophy, botany, anatomy, experimental chemistry and physiology, pathology and materia medica. In teaching clinical medicine Edinburgh gave the lead in following the Boerhaave 'system'⁷² of teaching. At that time there was a division in the medical world between those who, as in England, were content with the observation of facts (empirics) and those, like Boerhaave, who sought explanations (dogmatists). In the Boerhaave system adopted in Scotland the subjects to be taught in the medical schools were clearly defined and the relevant facts and theories were brought together and studied with 'sceptical dogmatism'. In the dogmatic nosology, diseases were grouped together according to a single outstanding characteristic (e.g. 'fever') and studied in relation to 'proximate cause' to give guidance on rational treatment and in relation to 'ultimate cause' to guide on prevention. By the middle of the century the Boerhaave system had been developed by William Cullen to a pattern that was followed thereafter in Edinburgh and Glasgow and adopted in North America.⁷³ Although Cullen's system was dogmatic it remained open to change in the light of new

⁷¹ Discussed in Chapter Eight.

⁷² M. Barfoot, 'Cullen's Medical Teaching; An Analysis of the Pedagogical and Epistemological Meaning of 'System' by Philosophy and Method' in A. Doig, J.P. Ferguson, I. A. Milne, and R. Passmore (eds.) *William Cullen and the Eighteenth Century Medical World* (Edinburgh, 1993), p.110.

⁷³ A. Doig et.al., 'Cullen's Influence on American Medicine,' *Ibid.* p. 40.

evidence. 'No man can go much further than the state of science at his particular period allows him,' and it was only 'the combination of philosophy with the facts of physic that could make any considerable change to the state of the art.'⁷⁴

Cullen made certain that no student at Edinburgh or Glasgow could graduate without attending the set classes⁷⁵ and satisfying the examiners.⁷⁶ (Cullen tried without success to persuade government to introduce Royal Commissioners to inspect all medical schools in the United Kingdom to correct abuses and to ensure that medical degrees were only given after two years student training before examination. The recommendations were eventually incorporated in the Medical Act of 1858.⁷⁷)

Although education in the Scottish medical schools was progressively modified in the nineteenth century, in its principles it continued unchanged. While a few Scottish graduates went on to achieve great success in entrepreneurial private practice in Harley Street or elsewhere they continued in the systematic science based Scottish tradition. The most ambitious and, in due course, the leading Scottish physicians re-enforced their roots in medical science by extending their postgraduate training in the leading institutes in Europe. In 1935 most physicians at Edinburgh Royal Infirmary⁷⁸ had received part of their training in Vienna, Freiburg, Berlin, or Heidelberg; in Glasgow, the physicians of the Western Infirmary, with only two exceptions had postgraduate experience in Paris, Vienna, Berlin or Strasbourg.⁷⁹ This contrasted with the relative neglect of scientific interest and training among the

⁷⁴ W. Cullen quoted by Barfoot, *op.cit.*, p. 119.

⁷⁵ Lectures could be attended by those with only limited interest in medicine and who did not intend to graduate. Church of Scotland ministers often attended medical courses in preparation to taking up their parish duties.

⁷⁶ Until the nineteenth century St Andrew's University, King's College, Aberdeen, and Marischal College, Aberdeen offered almost no training and conferred medical degrees on personal recommendation and the payment of a fee. This was thought by some to undermine the reputation of the high quality Scottish degrees from Edinburgh and Glasgow.

⁷⁷ C. Clayson, 'William Cullen in Eighteenth Century Medicine' in Doig et al., *op.cit.*, p. 94.

⁷⁸ Edinburgh Royal Infirmary and Glasgow Western Infirmary are cited since they were the main teaching hospitals in Scotland's largest medical schools.

⁷⁹ *Medical Directory*, 1935.

physicians of England who remained deliberately committed to empiricism. In 1935 none of the physicians of the London Hospital, St George's Hospital or St Mary's Hospital had received any training outside Oxbridge and the London teaching hospitals. St Bartholomew's, St Thomas's, St George's, Guy's, Middlesex, and Westminster Hospitals each had one physician with postgraduate scientific training (in, respectively, Munich, Berlin, Frankfurt, Munich, Vienna and Vienna). King's College Hospital had two (Gothenburg and Freiburg). The only physician on the staff of University College Hospital with postgraduate training (Freiburg) was a Glasgow graduate. Charing Cross Hospital also had two, one an Edinburgh graduate (Munich) and the other a Dublin graduate (Berlin and Frankfurt).⁸⁰

In London the leaders of the medical profession did not owe their position to their place in medical science but to their place in society. They exercised their considerable influence with government through personal contact with their wealthy and influential patients and through the London Royal Colleges that they dominated.

In Scotland there was no such medical elite with established and continuing private access to the country's leading figures. While private practice flourished at a certain level in Scotland it was not linked to an hierarchical society that could at its top support a body of elite and influential doctors. In consequence, in Scotland, there was no influential medical elite to confer privately with members of the government. Unlike the Royal Colleges in London, the Scottish Royal Corporations were not traditionally consulted by government.⁸¹ The medical profession in Scotland had no voice 'at court' to compare with that of the institutionalised elite in London. The medical members of the Cathcart Committee, chosen to advise on the future of health services in Scotland were not drawn from a body of successful patrician clinicians. They belonged also to a profession that looked for its leadership among those who had distinguished themselves in public service or in medical science.

⁸⁰ Ibid.

⁸¹ Appendix I.

Cathcart and his Philosophy

In the 1930s, Professor Cathcart was respected and his position as a leader of the medical profession in Scotland was unquestioned. However, outside Scotland, and especially among medical scientists, he had become a controversial figure caught up in two contemporary disputes.⁸²

In the early years of the twentieth century, a group at Glasgow University⁸³ led by Noel Paton, the Professor of Physiology, and Leonard Findlay, Lecturer in the Disease of Childhood, had established a reputation for their work on nutrition and on the aetiology of rickets. For them, and in the Scottish tradition, physiology was one of the Institutes of Medicine⁸⁴ to be studied in association with clinical observation and practice. In 1918, their position was challenged by the emergence of a new generation of laboratory-based medical scientists. Frederick Lowland Hopkins had been appointed to the foundation chair at Cambridge in 1914, the first Professor of Biochemistry in the United Kingdom. Since there was then only a small medical faculty at Cambridge and no clinical teaching, Hopkins' work was confined to the laboratory. He had established his reputation in the investigation of the 'accessory food factors' initially in relation to beri-beri, not then or since a clinical problem in man in the United Kingdom. His interests widened to include the study of other animal models of disease and in 1918 one of his group, Edward Mellanby, working

⁸² These controversies have been discussed in D. Smith and M. Nicolson 'The "Glasgow School" of Paton, Findlay and Cathcart; Conservative Thought in Chemical Physiology and Nutrition', *Social Studies in Science*, xix, 1989, p. 195; D. Smith and M. Nicolson, 'Chemical Physiology Versus Biochemistry: The Glaswegian Opposition to Mellanby's Theory of Rickets,' *Proceedings of the Royal College of Physicians of Edinburgh*, viii, 1989, p. 51; M. Mayhew, 'The 1930s Nutritional Controversy', *Journal of Contemporary History*, xxiii, 1988, p. 445; D. Smith and M. Nicolson, 'Nutrition, Education, Ignorance and Income – A Twentieth Century Debate' in H. Kamminga and A. Cunningham (eds.) *The Science and Culture of Nutrition, 1840-1940* (Amsterdam, 1995), p. 288.

⁸³ Often referred to as the 'Glasgow School' following the publication of L. Findlay, A Review of the Work Done by the Glasgow School on the Aetiology of Rickets, *Lancet*, i, 1922, p. 825.

⁸⁴ In earlier times, the sciences relating to medicine, such as physiology, were known as the Institutes of Medicine and were taught by clinical professors who might expect to be promoted later to be Professors of Medicine.

with pups, claimed to have shown that rickets was caused by a lack of an accessory food substance in the diet.⁸⁵

Leonard Findlay, on the basis of his extensive experience of what was then a very common condition in Glasgow, had already published his conclusion that rickets was not a dietary problem but was probably caused by lack of exercise and time spent in the open.⁸⁶ In 1918, Margaret Ferguson, another member of the Glasgow Group, had again reached the conclusion that 'inadequate air and exercise seem to be potent factors in determining the onset of rickets.'⁸⁷ However, the Medical Research Council (MRC) had been persuaded by Hopkins that 'accessory factors' (vitamins) were of vital importance in nutrition and had accepted Mellanby's experimental evidence of their role in the aetiology of rickets. A memorandum for famine relief workers produced by the MRC's newly appointed Accessory Food Factor Committee in July 1919 included recommendations based on the dietary deficiency theory of rickets.⁸⁸

Paton was dismissive of Mellanby's work and scornful of all those who wished to separate medical science from medical practice.

They indeed become a real danger to the advance of knowledge. Starting from nowhere and going no-whither, generally ignorant of what has to be done and not seeing what to do, they flicker their silly lamps in all directions and only obscure the path of real progress.⁸⁹

⁸⁵ E. Mellanby, 'The Part Played by an 'Accessory Factor' in the Production of Experimental Rickets', *Journal of Physiology*, lii, 1918, xii; E. Mellanby, A Further Demonstration of the Part Played by Accessory Food Factor in the Production of Experimental Rickets, *Journal of Physiology*, lii, 1918, liii.

⁸⁶ L. Findlay, 'The Aetiology of Rickets: A Statistical and Experimental Study', *BMJ*, i, 1908, p. 965.

⁸⁷ M. Ferguson, 'Social and Economic Factors in the Causation of Rickets', *Medical Research Council Special Report Series No. 20* (London, 1918), p. 94.

⁸⁸ *Some Facts Concerning Nutrition for the Guidance of those Engaged in the Administration of Food Relief to Famine Stricken Districts* (London, 1919).

⁸⁹ D. N. Paton, *Edinburgh Medical Journal*, xxxv (1928), p. 10.

The Glasgow Group continued to argue that rickets was not essentially due to a deficiency in the diet⁹⁰ although, by 1920, Paton was willing to concede that feeding might play some part in its control.⁹¹ However, scientific opinion strongly supported Mellanby and Glasgow lost its position as a major centre for MRC- funded research on rickets.⁹² Findlay moved to private practice in London and Paton died an embittered man in 1928.⁹³

Cathcart, who succeeded to the Glasgow Chair of Physiology on Paton's death, had no difficulty in accepting the laboratory evidence that accessory food factors had a role in nutrition but he remained sceptical of the clinical importance attributed to them. In relation to rickets his views were vindicated in 1973 when it was discovered that the form of vitamin D essential for the prevention of rickets was produced by the action of sunlight on the skin.⁹⁴ But in the 1930s he was on the wrong side of the argument and, in the later judgement of historians, thought to be exhibiting an unfortunate 'conservative style of thought.'⁹⁵

Although he had differed so publicly with the MRC,⁹⁶ Cathcart retained the confidence of the Ministry of Health and in Parliament the Minister, Sir Kingsley Wood, quoted him as a preferred authority.⁹⁷ It was this that once again involved him

⁹⁰ D. N. Paton, L. Findlay, and A. Watson, 'Observations on the Cause of Rickets', *BMJ*, ii, 1918, p. 625.

⁹¹ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', *op.cit.*, p. 202.

⁹² *Ibid.*, p. 204.

⁹³ *Ibid.*

⁹⁴ In 1973 it was shown that even in subjects taking oral supplements of vitamin D, over 80% of the circulating vitamin D was in the 25 OHD form produced in the skin by the irradiation of ergosterols by ultraviolet light. J. G. Haddad and T. J. Hahn, 'The Natural and Synthetic Sources of Circulating Hydroxyvitamin D in Man', *Nature*, ccxlv, 1973, p. 515.

⁹⁵ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', *op.cit.*, p. 197 and p. 223.

⁹⁶ *Ibid.*, p. 204.

⁹⁷ *Hansard*, cccxiv, HC 8 July 1935, col.1243.

in controversy and led to criticism of his attitude to the health of the urban working class.⁹⁸

By the end of the nineteenth century there were growing fears that as a consequence of the industrialisation of the nation and the urbanisation of the great mass of its people, the population of Britain had been afflicted by physical degeneration. Over a third of the men who presented themselves for recruitment to the army during the Boer War were found to be poorly grown and underweight. To many commentators it seemed evident that the urban working class was badly fed and that this must be attributed to poverty.⁹⁹ The evidence produced by John Boyd Orr at the Rowett Institute in the 1920s¹⁰⁰ and in his *Food, Health and Income*¹⁰¹ in the 1930s was widely thought to have put this conclusion beyond doubt.

Government, however, was content to believe that the state welfare measures in place - old age pensions, National Insurance, maternity and child welfare schemes - had abolished poverty. The Ministry of Health did not 'wish to know about other evidence that equated undernourishment with low income.'¹⁰² As early as 1906 government had blamed any deficiencies in diet on ignorance and carelessness.¹⁰³ This had been the conclusion of Paton and his colleagues after surveys in Edinburgh in 1901¹⁰⁴ and in Glasgow in 1913.¹⁰⁵ That poor feeding was due to 'fecklessness' had become identified as the view of the Glasgow Group. By 1931 Cathcart had

⁹⁸ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', op.cit., p. 215.

⁹⁹ These arguments and the supporting evidence are reviewed by Mayhew, op.cit.

¹⁰⁰ Rowett Research Institute, *Family Diet and Health in Pre-War Britain* (London, 1955)

¹⁰¹ J. Boyd Orr, *Food, Health and Income* (London, 1937).

¹⁰² Mayhew, op.cit., p. 455.

¹⁰³ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', op.cit., p. 219.

¹⁰⁴ D. N. Paton, J. Dunlop, E. Inglis, *A Study of the Diet of the Labouring Classes in Edinburgh* (Edinburgh, 1901).

¹⁰⁵ D. E. Lindsay, *Report upon the Dietary of the Labouring Classes of the City of Glasgow* (Glasgow, 1913)

modulated the language but still believed that lack of education, poor marketing skills and bad cooking were to blame rather than poverty.¹⁰⁶

When pressed in the House of Commons by claims that in Britain in 1936 there was still widespread malnutrition due to poverty, the Minister of Health found it useful to quote Cathcart.

We often hear Sir John Boyd Orr quoted rather incompletely, but there is an equally eminent member of the Ministry of Health Committee who can, I suppose, be regarded equally as an authority, and that is Professor Cathcart. He says that malnutrition is due not so much to poverty as to ignorance and other causes of the same kind.¹⁰⁷

The Minister omitted to inform the House that, by 1936, Cathcart and John Boyd Orr were working together, that Cathcart had contributed to Boyd Orr's *Food, Health and Income* and had modified his views.¹⁰⁸ Although in 1936 Cathcart continued to give particular importance to education, he may be excluded from the judgement by David Smith and Malcolm Nicolson that the Glasgow Group 'advocated policies that served the interests of the professional and middle classes as against those of the working class.'¹⁰⁹ Cathcart belonged to that layer of Scottish society - comfortably off, well-educated, professional men and women - which felt an obligation to improve the lot of the less fortunate. His attitude was undoubtedly paternalistic and in seeking to improve the health of the people he intended, as Smith and Nicolson have observed, 'to preserve the forms of medical and scientific education which had become traditional in the Scottish universities.'¹¹⁰

Professor Cathcart was therefore eminently qualified to speak for medical practice in Scotland. Soon after succeeding Noel Paton as Professor of Physiology at

¹⁰⁶ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', op.cit., p. 218.

¹⁰⁷ Hansard, op.cit.

¹⁰⁸ Sir John Brotherstone, 'The Development of Public Medical Care 1900-1948', in G. McLachlan (ed.), *Improving the Common Weal* (Edinburgh, 1987), p. 82.

¹⁰⁹ Smith and Nicolson, 'The "Glasgow School" of Paton, Findlay and Cathcart', p. 223.

¹¹⁰ Ibid.

Glasgow in 1928 he had begun to devote much of his energy to the work of a number of advisory bodies, both national and international. He became respected as a medical philosopher and statesman who promoted the new concept that the practice of clinical medicine should be primarily the promotion and maintenance of the 'constructive physiology' of the individual. This concept had emerged from the new discoveries of physiology, then the discipline at the forefront of medical science. Fuller understanding of the body's mechanisms seemed to offer the prospect that they could be successfully manipulated to correct abnormalities and maintain normal health.¹¹¹ This new form of preventive medicine for the individual was particularly welcome at a time when specific cures were still virtually unknown.

In Scotland, Sir Donald MacAlister,¹¹² in *A Scheme of Medical Service for Scotland* in 1920,¹¹³ had already set out an 'exposition of some general principles' which should govern the future practice of medicine. In addition to Public Health measures and the medical treatment of individual patients, greater attention should be given to 'safeguarding of the individual health'. This view was promoted in the Scottish medical schools. In his lectures at Glasgow in 1932, A. K. Chalmers¹¹⁴ argued that general practitioners should not confine themselves to the treatment of recognisable ailments but should actively promote the health of their patients. In his lectures, which were published in the *Glasgow Medical Journal*, Chalmers quoted Aristotle – 'health is no quiescent state, but a condition of unstable equilibrium maintained by continuous struggle.'¹¹⁵

This emphasis on maintenance of normal physiology represented a radical shift of ideas. In the second half of the previous century, physicians had been guided by the sciences of morbid anatomy and bacteriology. Without curative medicines the

¹¹¹ This concept was promoted during my years as an undergraduate.

¹¹² Chairman, Consultative Council on Medical and Allied Subjects, Scottish Board of Health; Principal of the University of Glasgow; President of the General Medical Council.

¹¹³ *A Scheme of Medical Services for Scotland*, 1920, Cmd.1039. (MacAlister Report)

¹¹⁴ Medical Officer of Health for Glasgow.

¹¹⁵ A. K. Chalmers, 'Our Provision for Treating the Sick', *Glasgow Medical Journal*, cxvii, 1932, p. 1.

expertise of the physician lay in the diagnosis and the mitigation of the symptoms of disease.¹¹⁶ His reputation, within the profession, was determined by his success in predicting the precise morbid changes that would be found in the post-mortem room.¹¹⁷ This was 'Mortuary Medicine' academically satisfying but of limited immediate benefit to the patients.¹¹⁸

In the 1930s, with progress in the science of physiology and the increasing understanding of the maintenance of normality, the perspectives of the medical profession were already changing. Supported by a growing canon of research, it was possible to look on the practice of medicine as 'constructive physiology', the promotion or restoration of normal function. The treatment of disease, although still continuing to form the bulk of practice, could be regarded as secondary. Professor Cathcart, as an eminent physiologist, was an advocate of the widest interpretation of this constructive physiology. 'His interest in physiology was broad based. He was concerned with the Nature of Man and not with a mere corner of the human organism.'¹¹⁹

In June 1933, the month of his appointment to the Committee on Scottish Health Services, he set out his ideas in an address to the Anderson College of Medicine in Glasgow.¹²⁰ He described how the practice of medicine should be reshaped, not only in the interest of the individual but in order to promote the fitness of the nation. He predicted that the future of medicine was in prevention:

¹¹⁶ In this period, the surgeon's skill was based on anatomy and he was occupied by the new opportunities following the introduction of aseptic surgery and more sophisticated anaesthesia. The obstetrician was still taken up by the unsolved problem of puerperal sepsis.

¹¹⁷ As a student in the late 1940s I was still taught that a 'case' was not 'complete' until it had been followed to the post-mortem room.

¹¹⁸ J. S. Fairbairn, 'Changes in Thought in a Half Century of Obstetrics', *Edinburgh Medical Journal*, xvii, 1935, p. 63.

¹¹⁹ Minute of Council, Royal Faculty of Physicians and Surgeons of Glasgow, 1 March 1954.

¹²⁰ E. P. Cathcart, 'Preventive Medicine and Public Health', *Glasgow Medical Journal*, cxix, 1933, p.185.

I do not anticipate, of course, that disease will vanish, that epidemics will cease, that immortality is within our grasp; in other words that the practice of medicine, as ordinarily conceived, will be exterminated in the near future. To hold such views would be the height of folly; but what will surely happen is that the earliest divergences from the so-called normal physiological state will be more readily detected, that, wisely or unwisely, the expectation of life will definitely be increased, that epidemics will be nipped in the bud, before, that is, they assume gross proportions. The aim of investigation will be the narrowing of the present gap which exists between perfect physiological normality and openly confessed disease. The difficulty, as I see it, will not so much be the detection of the earliest manifestation of disease, but the fixation of what is true normality, of the perfect physiological state.¹²¹

This perfect physiological state included not only the efficient functioning of the bodily systems –‘circulatory, digestive, and so on’- but the mind, since it was clear that the healthy happy mind was intimately related to the functioning of every other physiological system. Cathcart regretted that psychology had ever been divorced from physiology. ‘What medicine wants today more than any thing else is a true conspectus of the state of health.’

In giving priority to the maintenance of health over the treatment of disease Cathcart proposed a change in the role of the general practitioner.

Until it is thoroughly appreciated that unless and until your ordinary medical attendant knows perfectly your condition when you are well and fit, it will be impossible for him to detect the earliest signs of unfitness or disease. The doctor should not be regarded as one of the necessary evils of the sick-bed, as a man who has to be called in when you are stricken with disease, be it slight or severe, but as one who has your health and fitness in his charge and who can advise you as to the best measures to adopt in order to maintain your individual normal or to assist in restoring you to that normality.¹²²

In giving prevention priority over palliation of disease, the state would be faced with difficult questions of ethics and morality:

¹²¹ Ibid.

¹²² Ibid., p. 187.

Immediately allied to preventive medicine is Public Health, - the application of preventive medicine to the community at large. Right and proper though this application of preventive medicine to the community may be, it may also, when looked at from another angle, be regarded as a deadly menace to the State. It is no doubt a good thing to applaud this manifestation of philanthropy as given by the State and the communal authorities at the cost of the taxpayer but there is a reverse side to this shield which, not being very attractive, is rarely looked at. Remember it is promiscuous philanthropy which is practised, general not selective. Look, for instance, at one of the many applications; the perpetuation of the unfit, the prolongation of the lives of the insane. It is, of course, difficult in cold blood to condemn these earnest endeavours, but why look askance at birth control and the sterilisation of the unfit.¹²³

Above all, the maintenance of a healthy race would require the active participation and co-operation of every individual member of the community. Cathcart believed that this could be achieved by education of the public:

The progress of the future will be slower because the object to be attacked is man. Material things, no doubt, offer resistance, ordinary physical resistance, but they can always be overcome given time, patience and money. But man, feeble, pliable and of limited life as compared to the material obstacles of Nature, is resistant, conservative and stubborn. Time, patience and money may do much to overcome this human barrier to progress, but there is no certainty in the efficacy of any of these weapons. On the three, time, not counted in days or months but in decades, is the weapon of choice in this duel *a outrance*. Not because time is like an abrasive that will wear away any form of recalcitrant material, but because it will give the needed opportunity for education. Education and good will on both sides and faith are the only solvents of the difficulty...but it is a matter of supreme difficulty to convince ill-educated man in the mass...

To put it very broadly, the public authorities have now to assist at the birth of a new civilisation. The outlook of the man in the street, especially those least well endowed, has to be broadened. It is not merely that he, and far more important than the normal wage earner is the housewife, has to be educated as regards his nutrition and his housing, but he has to be educated in the proper use of his life.¹²⁴

Cathcart went on to emphasise that there are hazards to health other than from disease and that these must be taken into account in the education of the public:

¹²³ Ibid., p. 188.

¹²⁴ Ibid, p. 190.

All around us we hear the cry for rationalisation of industry. This means the better fitting out of shops with up to date machinery for the more economic production of goods. The aim of all modern machinery designers is to make machines automatic. What necessarily follows is that fewer and fewer workers are employed or shorter shifts will be worked. And hence the average working man will have more and more compulsory leisure. Is man at present fitted to utilise in proper fashion, to utilise to his good and not his detriment, his leisure hours? As Dean Inge has well said- 'A man's soul is coloured by the colour of his leisure thoughts.' The right use of leisure will become in the end as urgent and dominant a cry as the right use of machinery. It is infinitely easier to degenerate through excess of leisure than through the excess of work. Hard work never killed a sound, healthy man, but too much leisure may easily ruin him physically and spiritually. The majority of people have not yet grasped the dangers of leisure, its soul-destroying evils- gambling, drink and the rest. Those in control of the community must take thought to this gigantic problem, the insidious dry rot of the community and the State.¹²⁵

In this exposition of his ideas Cathcart made it clear that, for a healthier nation, he looked essentially to the creation of a more enlightened society. At the same time, the process of improvement would also require greater intervention by government in personal health care. It was equally clear that he intended that that intervention and control should be for the benefit of the whole population and should not be confined only to those defined sections of society recognised as having special needs.

Professor Cathcart accepted without question that the state should accept the role of *paterfamilias*. In this he was neither original nor unique in 1933. That the state should intervene to show people how to live and be healthy was accepted across the political spectrum of inter-war Europe.¹²⁶ It represented a view that had been growing in strength in Scotland for some years and was shared by the medical members of the Cathcart Committee and sat easily with a Scottish tradition of medicine based on science and system. Intervention by the state was inevitably less acceptable to the medical profession in England whose leaders held that the individual patient must be

¹²⁵ Ibid, p. 191.

¹²⁶ M. Mazower, *Dark Continent* (London, 1998), p. 78.

‘king’,¹²⁷ and that health did not ‘depend on science at all.’¹²⁸ The Committee on Scottish Health Services began work with a set of assumptions that were natural in Scotland but alien to the most influential leaders of the medical profession in England.

The Cathcart Committee was therefore an appropriate instrument in Sir Godfrey Collins’ policy of taking an independent Scottish line in making state provision for the health of the people of Scotland. Collins had shown that in the 1930s there was in Scotland the political will to have health services appropriate to social conditions as they were then in Scotland and designed to meet the country’s particular needs. In his re-structuring of the Scottish Office he had created a bureaucracy to administer those services. In appointing the Committee on Scottish Health Services he had brought together people well qualified to advise on how that should be done as a development of existing Scottish practices and in accordance with Scottish values in the practice of medicine. The Committee had found in Edward Cathcart an eminent spokesman who could present the consensus view and articulate the philosophy on which it was based.

¹²⁷ Lord Horder in an address to Westminster Hospital Medical School, 28 September 1936. Horder, 1937, *op.cit.* p. 30.

¹²⁸ Lord Horder in a BBC talk, 5 April 1937. *Ibid.*, p.104.

CHAPTER THREE

THE CATHCART REPORT: CONTEXT AND INTENTION

It was not the primary purpose of the Cathcart Committee to launch a revolution that would turn the history of the provision of health care or even to create in Scotland a system of health care essentially different from that in England and Wales. The purpose was to find a way to restore the health of the people of Scotland and to repair the deficiencies in the health care system that had so clearly failed to protect the people in the economic distress of the 1920s and 1930s. The Committee was commissioned to carry out an urgent 'review of the health services in Scotland in the light of modern conditions and knowledge and to, make recommendations in policy and organisation that may be considered necessary.'¹ The Committee saw that the review could not be confined only to statutory health services. An adequate assessment of the problems of the 1930s would be 'impossible ...without taking account of the work of the general medical practitioner in private practice, the voluntary hospitals and the many other private and voluntary agencies that are concerned with health.'² The intention was to reshape and improve the existing structure, not to condemn the mistakes of the past or to abandon completely all or any of the health services that had been created earlier in the century. The Committee's intention was to salvage and adapt those components of the exiting system that might prove useful in the present crisis.

While the immediate need was to restore damage done in the past, there was also an ultimate purpose to 'promote the health of the people'.³ In inter-war Europe other countries were reshaping their health services with the same objective. The promotion of sound health and well being of the individual citizen was a humanely

¹ Cathcart Report, p. 9.

² Ibid., p. 9.

³ Ibid.

desirable objective. But in the insecurity of the time, when nation states were in dangerous rivalry with each other, the state also had a vital interest in the health and strength of its people. Across the political spectrum in a number of countries in Western Europe there was pressure for the state to intervene in private life to show people how to live in order to be fit to serve the nation.⁴ The potential benefits of the collective management of the health of the human stock of a nation were unquestionable both to the individual and to the state. However giving first place to the interests of the state raised moral and ethical problems. It could be argued that, in the biological management of the people, the removal of the genetically unfit, the mentally defective, the chronically disabled and the criminal was rational and desirable and therefore ethically acceptable. In the 1930s sterilisation schemes were introduced in Germany, Switzerland and Sweden and continued for many years. By 1936 Germany was already going to extremes in creating a racial welfare state but the idea that, in addition to providing necessary health services, the state should intervene to guide the individual in promoting his own health had become common currency in Europe in the 1930s. The Cathcart Report did not explicitly relate its search for a new health policy to this European movement but, given the associations of its medical members with universities in Europe, it must be assumed that the Cathcart Committee was alive to the possible advantages in taking the same line.

In the 1930s there was clearly no point in continuing in conformity with England. The tariff barriers raised to stop the decline in the trade balance had created an economy that could not easily support social reform (the idea that the tariffs themselves could finance social reform was an illusion). In England the health services were not under review and their reform was not being contemplated. The Westminster administrations of the 1930s were eager to show that, even during the Depression, state pensions and National Insurance had abolished poverty and that the health of the people was being well maintained by local authority services and the

⁴ M. Mazower, *Dark Continent* (London, 1998), p. 78.

medical benefits of the National Health Insurance Scheme. Such satisfaction might be justified at the seat of power, on the evidence from London itself and from that part of England to the south and east of Birmingham where a level of prosperity was maintained by new light industries and an associated building boom. But in the industrial North and in Wales the problems of unemployment and social distress were undeniable. There the old heavy industries had been in decline since the end of the war. In its original form the National Insurance Scheme and the associated health benefit could not cope with the rising numbers of unemployed and their deteriorating health. Between 1920 and 1926 there had been no less than fifteen Insurance Acts to a volume of unemployment that had not been foreseen⁵ and in the process the insurance principle had been almost entirely abandoned. In the 1930s the problem in the industrial north increased as the cyclical short-term employment for which the National Insurance Scheme had been planned changed to deep-seated long-term unemployment and the level of unemployment rose to new heights. In 1924-29 economic depression had brought an end to any forward movement in social reform;⁶ in the 1930s social policy in England was on the defensive, dominated by the struggle to contain the cost of the massive unemployment in the north and in Wales. England was two nations and voters in the prosperous south-east were in the majority and not necessarily willing to make sacrifices to relieve the problems in the industrial provinces. The preoccupation of Government and the Ministry of Health in the 1930s was to persuade the public that, in a time of financial difficulty, there was no pressing need for great investment in a new program for health. The public in London and in the south-east could be easily persuaded of the soundness of government policy; in the industrial provinces of the north and west the government's benign assessment of the effectiveness of welfare services was demonstrably wrong and to the public the government's policy seemed unjust. On the need for reform of health and welfare services England was divided.

⁵ J. Davis, *A History of Britain 1885-1939* (London, 1999), p. 150.

⁶ *Ibid.*, p. 212.

There was no such division in Scotland. Industrial decline and unemployment affected every part of Scotland and the effects on the well-being of the people were visible everywhere. There was no prosperous and flourishing community with interests in conflict with those of the mass of the country's population in the industrial central belt. The Cathcart Committee had to plan for one people united in the social distress of the 1930s. Unlike the Ministry of Health, the Department of Health for Scotland had made no attempt to disguise or to minimise the problem; the evidence was set out year by year in its Annual Reports. The Secretary of State and a devolved administration looked to the Cathcart Committee for a new policy for health, clearly necessary for Scotland at that time, while the Ministry of Health remained determined to justify and maintain its existing policy for England and Wales. In the London administration there 'existed a consensus to prevent any thing unusual from happening.'⁷ The Cathcart Committee produced a scheme for the reform because of the urgency of the need for such reform in Britain in the 1930s and because, in Scotland, that need had been frankly acknowledged by a devolved administration; but the policy was not intended to be so idiosyncratic that it could not be followed later elsewhere in Britain.

In its Report, the Cathcart Committee stated that it would review the histories of existing health services 'to discover the purposes for which they were instituted and whether there were any leading principles that have determined their development and may be taken as a guide for the future.'⁸ The lessons taken from these histories will be considered in the relevant chapters later in this thesis. At this point it seems necessary only to show that these services, established in Scotland early in the twentieth century, had been established within a British context and had not created a state health care system in Scotland that was essentially different from that of England and Wales.

At the beginning of the century Sir George Newman drew attention to a change then taking place in the concept of public health in Britain. 'The centre of

⁷ P. Addison, *The Road to 1945* (London, 1994), p. 14.

⁸ Cathcart Report, p. 11.

gravity of our public health system is passing from the environment to the individual and from the problems of sanitation to the problems of personal hygiene.’⁹ For more than a century, the crowding of an enlarging population into the country’s industrialised centres had exposed the people, particularly the poor, to new risks of contagious disease and sudden and early death. These risks had been contained by the sanitary measures in the second half of the nineteenth century. But nothing had been done to relieve the effects of chronic poverty on the physical and mental well being of a very large proportion of the population. The problem of poverty may not have become worse at the end of the nineteenth century but there was by then a growing consciousness of the evils of unemployment and poverty.¹⁰ Sensational publications such as *The Bitter Cry of Outcast London* serialised in the Paul Mall Gazette in October 1883 and General William Booth’s *In Darkest England*¹¹ in 1890, had drawn public attention to this social problem and its extent had been measured in the surveys of Charles Booth in London in 1889¹² and by Seebohm Rowntree in York in 1901¹³. Dispassionate concern was heightened to interested alarm by the inadequate performance of the British Army during the Boer War. The effectiveness of British institutions was questioned and a cult of Efficiency was taken up for a time by politicians of both main parties and by the management of many public and private bodies. However it was the strength of the population that caused greatest concern. It was generally accepted that national strength depended on the size of the population and the fitness of its individual members. The problems immediately identified were the decline in the size of the population, attributed to a falling birth rate, and an appallingly high death rate among infants during the first year of life that seemed to threaten the strength of the nation (‘our successors will be unable to bear the burden of empire’ as ‘the human reservoirs of the country dry up’¹⁴). Second, the lack of

⁹ Sir G. Newman, *The Health of the Nation* (London, 1907), p. 7.

¹⁰ G. Finlayson, *Citizen, State, and Social Welfare in Britain* (Oxford, 1994), p. 106.

¹¹ W. Booth, *In Darkest England* (London, 1890).

¹² C. Booth, *Life and Labour of the People of London* (London, 1902).

¹³ B. S. Rowntree, *Poverty: A Study of Town Life* (London, 1902).

¹⁴ Earl Grey, *The Times*, 26 February 1901.

physical fitness of the individual members of this diminishing population had become all too clear in the medical examinations of those presenting themselves for recruitment into the army during the war. A third and later concern was for the health and welfare of the workers in the country's essential industries.

These were the problems addressed by government legislation in the few years before investment in social reform was halted by the First World War and by the economic decline in the 1920s. In 1902 a Royal Commission was appointed to discover whether the physical education of children and adolescents would 'contribute to the national strength.'¹⁵ The investigation was carried out in Scotland by Leslie Mackenzie and Matthew Hay. The results prompted the appointment of the Inter-Departmental Committee on Physical Deterioration¹⁶ and the creation of the School Medical Service followed both in Scotland and in England and Wales. It was soon pointed out in Scotland that, in the promotion of the health and development of the country's progeny, more could be achieved by directing resources to the care of infants and pregnant mothers.¹⁷ This became widely understood throughout Britain. Maternity and child welfare schemes were added to those few already established by charity organisations and local authorities. Central government increased the efficiency of these schemes in the Notification of Birth Act of 1907 and the Notification of Birth (Extension) Act on 1915. The Royal Commission on the Poor Laws and the Relief of Distress reported in 1909. While its Majority Report gave support to the *status quo*, the Minority Report, to which John McVail, the Medical Officer of Health of Stirlingshire, had been an important contributor, recommended the abolition of the Poor Law and the creation of a more unified system of health care. The recommendations of the Minority Report were set aside until after the First World War, but they had increased the momentum for creation of a new government

¹⁵ *Report of the Royal Commission on Physical Training (Scotland)*, 1903, Cd. 1507, p. 7.

¹⁶ *Report of the Inter-Departmental Committee on Physical Deterioration*, 1904, Cd. 2175.

¹⁷ *Glasgow Herald*, 7 December 1906.

department to improve the organisation country's health services, leading to the later creation of the Ministry of Health and the Scottish Board of Health in 1919.

Scottish experience had helped to make the case for change in Britain and in these early years of the century, but the resulting initiatives were British initiatives. The new services - the School Medical Service and Maternity and Child Welfare Services - did not call for new administrative structures but were grafted on to existing Scottish organisations, the Scotch Education Department, local authorities and charity organisations. The creation of a welfare bureaucracy in Scotland came a few years later.

A Separate Welfare Bureaucracy.

The health services of Scotland would not have been separately reviewed in the 1930s and a new policy for health would not have been devised had there been no separate administration in Scotland. This devolution of administration has been studied by a number of historians.¹⁸ In *The Autonomy of Modern Scotland*¹⁹ Lindsay Paterson has described the crucial role played by a separate bureaucracy in shaping the governance of Scotland:

The argument is not that Scotland had control over its own legislation, although it could influence that. The key point is [that] the politics that mattered were those of the bureaucracy, in the sense that the autonomy and distinctiveness of any country in the mid-twentieth century rested more on the way its bureaucracy interpreted legislation than on the legislation itself. Scotland had its own welfare state bureaucracy.²⁰

¹⁸ C. Harvie, *Scotland and Nationalism* (London, 1977); C. Harvie, *No Gods and Precious Few Heroes* (Edinburgh, 1998); I. Levitt, *Government and Social Conditions in Scotland* (Edinburgh, 1988); I. Levitt, *The Scottish Office* (Edinburgh, 1992); L. Paterson, *The Autonomy of Modern Scotland* (Edinburgh, 1994); J.W.R. Mitchell, *The Evolution and Consolidation of Scottish Central Administration, 1885-1939*, unpublished DPhil thesis, University of Oxford, 1989.

¹⁹ L. Paterson, op.cit., p. 103.

²⁰ Ibid.

The seminal event was a last minute amendment carried at the final stage of the National Insurance Bill in 1911. A movement for Home Rule for Scotland was still being kept alive at that time by both the Liberals and by the new Labour Party in Scotland, but Home Rule for Ireland was a much more pressing issue with government. During the 1910 election Asquith had given an explicit pledge to introduce Home Rule for Ireland,²¹ adding a late complication for Lloyd George in his long and difficult struggle over his National Insurance Bill. As a Treasury Bill, it was initially designed to apply to all parts of Great Britain and Ireland. Asked if his Bill would be modified if Home rule were to be granted to Ireland, Lloyd George made it clear in May 1911²² and again in June that the Government had 'no intention of excluding Ireland from the benefits of the National Insurance Bill.'²³ However the introduction of his scheme was facing mounting resistance in Ireland. At a meeting at Maynooth in November 1911, the General Council of the Irish County Councils and the Catholic Archbishops and Bishops of Ireland had all agreed that the National Insurance Bill, however suited to an industrial population such as Great Britain, was quite unacceptable and even 'mischievous' in the wholly different conditions in Ireland.²⁴ In the House of Commons Lloyd George was asked to defer to this 'almost unanimous' expression of Irish opinion by excluding Ireland completely from the operation of the Bill.²⁵ But Irish members were not in fact as united as first claimed in rejecting the scheme completely. T. M. Healy, the Member for Louth, accepted the Bill in principle, objecting only to the proposal that 'the Commissioners are to be gentlemen residing solely in London.'²⁶ John Redmond on behalf of the majority of Irish members, promised to lend support to the Bill but only on condition that it was amended to make it more relevant to conditions in Ireland.²⁷ In November 1911, six

²¹ J. Grigg, *Lloyd George: The People's Champion* (London, 1978), p. 241.

²² *Hansard*, xxv, HC 10 May 1911, col. 1342.

²³ *Hansard*, xxvii, HC 29 June 1911, col. 567.

²⁴ *Ibid.*, col. 699.

²⁵ *Ibid.*

²⁶ *Hansard*, xxx, HC 24 October 1911, col. 74.

²⁷ *Ibid.*, col. 154.

months after the Bill had been presented to Parliament and three years after Lloyd George had begun work on his project, the Irish members presented a last minute list of amendments including a demand for a separate Irish Commission and a separate Irish Insurance Fund.²⁸ W.J. Braithwaite²⁹ later recalled that 'the political position was such, with the Parliament Bill on hand and Home Rule in the offing, these demands had to be acceded to and incorporated in amendments to the Bill.'³⁰ The relevant amendments were therefore formally drafted for presentation to the House of Commons at discussion of Clause 59 a scheduled for 13 November.

Clause 58, dealing with minor adaptations of the Bill for application in Scotland, was also due for consideration on the same day. On Friday 10 November a meeting of some dozen Scottish Liberal members decided to follow the example of the Irish members and demand a separate Commission for Scotland. Their demand was immediately accepted by the Lord Advocate and presented as a Government amendment on Monday 13 November. The majority of Scottish members had their first warning of this amendment only on the previous Saturday. Although several protested at the lack of time to consider, Lloyd George nevertheless agreed to the amendment because he 'thought that was the general view of Scottish members of the subject.'³¹ 'All I can say is that I regret the conclusion they have come to.'³² 'The Government proposal was to have one Commission for the United Kingdom and so treat the matter here, as in Germany, as an Imperial matter.'³³ According to Braithwaite, Lloyd George had simply become impatient after years of struggle and was 'pressing on now to finish regardless of anything. He wanted have done with it.'³⁴ That same evening the amendment was passed by 171 votes to 89, 'the hastiest piece

²⁸ The list also included the demand that the whole of Ireland should be excluded from the operation of that part of the Bill that provided Medical Benefit.

²⁹ W.J. Braithwaite was the civil servant chosen to assist Lloyd George at the Treasury in preparing his Health Insurance scheme.

³⁰ W. J. Braithwaite, *Lloyd George's Ambulance Wagon* (London, 1957), p. 223.

³¹ *Hansard*, xxxi, HC 13 November 1911, col. 64.

³² *Ibid.*, col. 61.

³³ *Ibid.*, col. 60.

³⁴ Braithwaite, *op.cit.* p. 224.

of legislation in the history of Britain.³⁵ The Scottish Commission, with its supporting staff, took up its duties on 1 January 1912. A separate welfare bureaucracy for Scotland had not been contemplated by government in the summer of 1911 but now one existed in embryo as an unforeseen by-product of the struggle over Home Rule for Ireland. Within two years a small increment had been added to the growth of that embryo bureaucracy by the creation of the Highlands and Island Medical Services Board. (Chapter One)

The Insurance Commission for Scotland and the Highland and Islands Board were significant precedents but when the movement began for the formation of a Ministry of Health during the First World War it could not yet be assumed that there would be separate provision for Scotland. The movement to create a Ministry had begun in August 1914 with the appointment of Christopher Addison as Parliamentary Secretary to the Board of Education.³⁶ Assisted by Sir Robert Morant, Chairman of the Insurance Commission,³⁷ Addison prepared a memorandum arguing for the amalgamation of no fewer than 14 government bodies to form a single health ministry. But in 1915 he was moved to the Ministry of Munitions and, for the moment, his plan came to nothing. In 1916, as one of the organisers of the coup that made Lloyd George Prime Minister, Addison became a Minister in his new Coalition Government, first for Munitions, then for Reconstruction. He was now in a position to resurrect his plan for a health ministry. There was strong resistance to his proposal from inside Government, especially from successive Presidents of the Local Government Board.³⁸ As he recorded in his diary, 'the struggle that went on behind the scenes for nearly two years to secure the establishment of the Ministry of Health is

³⁵ Ibid.

³⁶ Addison had been elected to Parliament in 1910 at the age of 41, having been Professor of Anatomy at Sheffield for the previous eleven years. As a leading medical member of the House of Commons he had assisted Lloyd George in the preparation of the NHI Bill; his chief contribution to the Bill was the clause which led to the foundation of the Medical Research Council.

³⁷ Morant had recently been the Permanent Secretary of the Board of Education.

³⁸ K. Morgan and J. Morgan, *Portrait of a Progressive: The Political Career of Christopher Addison* (Oxford, 1980), p. 75.

a good example of how difficult it is to secure the passage of an effective reform, even when, as in this case, it was supported by public opinion and by men of all parties.’³⁹

Addison’s most effective support came from outside the official organisation of government, from Lloyd George’s ‘Kindergarten’ (officially the Cabinet Intelligence Branch) and at informal meetings at Lloyd George’s home in Wales. At these meetings the interests of the medical profession was represented by Major General Sir Bertrand Dawson, physician to the King and at that time Consulting Physician to the British Armies in France. (Significantly, in view of Lloyd George’s previous experience in setting up his National Health Insurance Scheme, a representative of the BMA was not included in these unofficial meetings.) The purpose of these discussions was made public by Lord Astor (an ‘Honorary Kind’⁴⁰), first in April 1917 in his pamphlet *The Health of the People* and again on 13 October in an address to the Royal Institute of Public Health on *The Health Problem and a State Ministry of Health*. On 10th January 1918 he brought his case to wider public attention in a letter to *The Times*⁴¹ in which he called for the establishment of ‘a Ministry of Health to co-ordinate and develop measures for the health of the people throughout England and Wales.’ In his letter he made passing and obscure reference to ‘necessary matters in relation to Scotland and Ireland.’⁴²

In Scotland the case for a separate Ministry was first made by the Royal College of Physicians of Edinburgh in a memorandum to the Secretary for Scotland

³⁹ C. Addison, *Politics from Within* i (London, 1924), p. 221.

⁴⁰ C. Sykes, *Nancy: The Life of Lady Astor* (London, 1979), p. 198.

⁴¹ *The Times*, 10 January 1918. The letter was also signed by Charles Bathurst, Henry Bentinck, W. Hills, Henry Harris, W. Ormsby-Gore, R. A., Sanders, A. E. Weigall and Edward Moon.

⁴² The prospect of a Ministry of Health met with some early resistance in England. In October, Lloyd George found it expedient to assure a deputation of the Joint Committee of Approved Societies and the Amalgamated Society of Industrial Assurance that the Government did not intend ‘to give facility during the present session of Parliament for any measure to establish a Ministry of Health.’ (*BMJ*, ii (1917), p. 559). The *BMJ* commented: ‘There is a general impression that the mere suggestion to establish a Ministry of Health has aroused so much departmental jealousy that whatever form any Bill will take it will meet with strenuous opposition from one department or another.’

on 6 December 1917.⁴³ This was followed by matching memoranda from the Royal College of Surgeons of Edinburgh on 5th February 1918,⁴⁴ and from the Royal Faculty of Physicians and Surgeons of Glasgow on 8 April 1918.⁴⁵ The Deans of the Faculties of Medicine of the Scottish universities were informed of these memoranda and gave their support. The Court of St Andrews University declared its support for a separate Ministry in February 1918.⁴⁶ While each of these bodies acted separately, there had been open communication among them, establishing a clear consensus of view among the leaders of the medical profession in Scotland, the Royal Medical Corporations and the universities. (It is indicative of the relative unimportance of the British Medical Association in Scotland at that time that it was not included in the distribution of the many communications that passed between these various bodies.)

The Approved Societies in Scotland made their support for a separate Ministry known to the Secretary for Scotland in July 1918.⁴⁷ The views of the local authorities were presented by a deputation from the Convention of Royal Burghs, the County Council Association, and the Association of District Councils in Scotland to the House of Commons on 17 July 1918. In common with all other interested parties in Scotland the deputation

desired a separate Ministry for Scotland...The deputation wished the Secretary for Scotland to be nominally the Minister for Health with a Parliamentary Secretary as the responsible person for dealing with questions arising under the Public Health Act. Instead of one Bill for the establishment of Ministries for Scotland and for England, the view of the public authorities was that they would prefer the Scottish Ministry to be dealt with in a separate Bill.⁴⁸

⁴³ The Minutes of the College include the statement supporting a separate Ministry for Scotland but neither the Minutes nor the Minutes of Council record the reason for the statement being made at precisely that time.

⁴⁴ *Records of the Royal College of Surgeons of Edinburgh*, 16 May 1918.

⁴⁵ *BMJ*, i, 1918, p. 519.

⁴⁶ *Ibid.*, p. 243.

⁴⁷ NAS HH/1/469.

⁴⁸ *The Scotsman*, 17 July 1918. The deputation said that 'their experience was that Scottish matters dealt with in an English Bill, with English phraseology, was unsuitable and difficult to deal with in Scotland'.

That same evening in the House of Lords, the Government indicated that the case presented by the deputation had been accepted.⁴⁹ Next day, 18 July, the arrangements for Scotland were settled at a meeting of the Cabinet Home Affairs Committee:

The Secretary for Scotland said that the demand for the unification of the Health Services was as strong in Scotland as elsewhere, but whereas some were in favour of setting up a separate Minister of Health for Scotland, others would be satisfied if the Secretary for Scotland performed the duties of the Minister of Health. In as much, however, as the Secretary for Scotland was already charged with heavy responsibilities, the suggestion had been put forward that there should be a Parliamentary Under-Secretary for Scotland. The proposal had proved to be generally acceptable, and no opposition to it was anticipated from any quarter of the House of Commons. He had set out in his memorandum the modification which he suggested should be in the draft Bill so as to combine in a Ministry of Health *inter alia* the functions of the existing Local Government Board for Scotland and Insurance Commission for Scotland, and to provide for the appointment of a Parliamentary Under-Secretary.⁵⁰

The Scottish Board of Health Act, 1919 was passed without opposition. The only expression of disappointment in the House of Commons came from Sir Donald MacLean.⁵¹ His recommendation that the Ministry of Health Bill should provide for the break up of the Poor Law in England had been refused earlier on the grounds that this would cause considerable delay ('because of the complexity of the task.'⁵²) Since the Poor Law in Scotland was much less complex Sir Donald believed that it could have been abolished in Scotland by the Board of Health Act. His amendment to that effect was also refused.

In contrast to the 'extraordinary opposition'⁵³ to the creation of the Ministry of Health in London and the conflicts which resulted,⁵⁴ the creation of the Scottish

⁴⁹ *The Scotsman*, 18 July 1918.

⁵⁰ PRO CAB, 26/1 HAC 3rd:2.

⁵¹ Sir Donald MacLean had investigated the working of Public Assistance in England and Wales and had presented his Report on 19 December 1917.

⁵² *The Scotsman*, 3 December 1918.

⁵³ J. Macintosh, *Trends of Opinion about Public Health* (Oxford, 1953), p. 95.

⁵⁴ The conflicts have been described by F. Honigsbaum in *The Struggle for the Ministry of Health* (London, 1970).

Board of Health had been achieved without dissent. From 1 July 1919 the Board assumed the powers and duties of the Local Government Board for Scotland, the Scottish Insurance Commissioners, and the Scotch Education Department (with respect to the medical inspection and treatment of children and young persons) and, on 1 September 1919, the powers and duties of the Secretary for Scotland on the Highlands and Islands (Medical Services) Board. Sir John Pratt was appointed as an Under-Secretary at the Scottish Office to head the Board with the Secretary for Scotland, Robert Munro, as President and the responsible Minister.

The new Ministry of Health in England and Wales was formed on a model long established in Whitehall. The Minister of Health was supported by an hierarchical structure of civil servants headed by a powerful and influential Permanent Secretary. In Scotland the management structure was closer to that of a commercial enterprise with the Secretary for Scotland as President and the specially appointed Under-Secretary of State in the role of chief executive. Policy was determined by the Board, chaired by Sir George McCrae. The routine tasks of administration were carried out by a staff of 380 civil servants (279 previously with the National Insurance Commission, 94 from the Local Government Board, seven from the Highland and Islands Board) without a head in the influential position of a Permanent Secretary in Whitehall. 'Company' policy was guided by a board of six (later reduced to three) in the role of non-executive directors - the Scottish Health Board. Each Board member brought extensive experience in the management of one of the 'companies' taken over as a branch of the new organisation (Local Government Board for Scotland, Highland and Islands Board, Scottish Insurance Commission, Friendly Societies, local authorities⁵⁵). Both the Board and the executive were served by 'technical boards' in the form of its Consultative Councils.

The Scottish Board followed a pattern first devised for the administration of the Poor Law in 1885. Lindsay Paterson has described the relationship between these

⁵⁵ Appendix IV.

boards and society in Scotland.⁵⁶ The Scottish Board of Health, like other Scottish Boards centralised state power, but remained more closely embedded in society than a professional civil service department in Whitehall. It was made up of members brought to positions of influence through networks within the Scottish professional associations and the Scottish universities.⁵⁷ That part of Scottish society from which the members of the Scottish Health Board were drawn was small and those appointed were already well known to each other both professionally and socially. (All six of the members appointed in 1918 lived within convenient walking distance of each other in Belgrave Terrace or nearby in the West End of Edinburgh.) The Minutes of the Scottish Health Board⁵⁸ show no evidence of any significant differences of points of view or any diversity of purpose. Consensus over 'company policy' for Scotland was easily achieved by Board members who enjoyed a unity of purpose and maintained their links with society outside the circles of government and public administration.

The members of the Consultative Council on Medical and Allied Services, the most important of the Consultative Councils, were geographically more dispersed but came from the same section of Scottish Society and were appointed in a way that was distinctively Scottish and that strengthened an existing predisposition to consensus. In England four Consultative Councils were set up; for Medical and Allied Services; for National Health Insurance; for Local Health Administration; and for General Health Questions. In Scotland, the Chairman of the Scottish Board, Sir George McCrae, adapted this arrangement. By combining the committees on Local Health Administration and on General Health Questions he was able to accommodate a Highlands and Islands Consultative Committee while limiting the total number of committees to four in line with the arrangement in England.⁵⁹ Again attempting to conform as far as possible to a UK pattern, the Scottish Board consulted with the

⁵⁶ Paterson, *op.cit.*, p 51.

⁵⁷ Appendix IV.

⁵⁸ The Minutes of the Scottish Board of Health were examined while they were still in the possession of Miss Elizabeth Strong. They have since been acquired by the National Archives of Scotland.

⁵⁹ NAS HH/1/469.

Permanent Secretary of the Ministry of Health, on setting up the influential Consultative Council on Medical and Allied Services. The Ministry had devised a complicated scheme for England and Wales under which no few than 32 bodies were to be asked to submit an unlimited number of names; from this very large number of candidates, 20 were to be selected by a panel drawn from the Royal Colleges and the British Medical Association.⁶⁰ This scheme was rejected by the Scottish Health Board which opted instead to appoint its Consultative Council on Medical and Allied Matters directly and strictly according to the provision in the Act that ‘every Council should include persons of both sexes and should consist of persons having practical experience of the matters referred to the Council and that due regard should be had in constituting them to any special interest (including those of Local Authorities and of labour) which might be involved.’⁶¹ The selection of members of the Consultative Council on Medical and Allied Services was therefore made by the Board without concession to the British Medical Association or the Medical Corporations or to any other outside body. From the beginning the Consultative Council in Scotland therefore had a very different character from its opposite number in London. The 20 members of the Consultative Committee in Scotland were drawn from general medical and dental practice, consultant and specialist practice, public health, industrial medicine, laboratory services, nursing, pharmacy, the General Medical Council, and the BMA. Significantly, seven of those appointed were also heads of university departments.⁶²

This degree of importance and influence given to the Scottish Universities, even within a very broadly based advisory body, created a precedent that was followed thereafter, establishing a continuing difference in the route by which influential medical opinion was delivered to Government in Scotland and England and Wales. For centuries before the creation of the Ministry of Health, the Privy Council

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Appendix V.

and Whitehall had looked to the Royal College of Physicians of London for guidance on medical matters⁶³ and the BMA had won a position of influence during the struggles over the National Insurance Bill in 1911. The Royal Colleges in London and leaders of the BMA retained considerable influence in Whitehall even after the establishment of the Ministry of Health and they continued to exert pressure on government from outside and in the interest of particular sections of the medical profession. In Scotland the influence of a much wider spectrum of the medical profession was presented from within the system through the statutory advisory bodies and was most powerfully articulated in these bodies by their university based members.

By 1929, when the Scottish Health Board was replaced by the Department of Health for Scotland, there was already a well established habit of co-operation and unity of purpose within the health services and their administration. The distinctive health bureaucracy that served that consensus had grown with the years. In 1926 it was strengthened when the Scottish Secretary, Sir John Gilmour, became a Secretary of State with a seat in Cabinet. This conferred a useful increase in status on his civil servants. Their status was further increased two years later. In 1928, on the recommendation of the Royal Commission on the Civil Service, the Re-organisation of Offices Act replaced the Scottish Health Board and its idiosyncratic organisation of civil servants with a Department now brought within the ordinary civil service structure. The change was intended to ensure 'more effective responsibility for action and advice' and to facilitate 'the interchange of personnel between the Scottish Office [at Dover House in London] and Departments in Edinburgh.'⁶⁴ These new Departments, including the Department of Health for Scotland, were now hierarchical, each under a Permanent Secretary. The power and influence of Scotland's central bureaucracy was considerably increased. The new Departments offered an improved career structure, attracting higher calibre entrants. They also allowed increased scope

⁶³ Appendix I.

⁶⁴ NAS HH 1/526.

for the more ambitious civil servants in Scotland without need to shift their allegiance from Edinburgh to Whitehall. Under the Secretaries of State, Sir John Gilmour and Sir Godfrey Collins (and later Walter Elliot and Tom Johnston) greater authority was devolved to Edinburgh establishing the new Scottish Office as the centre of effective governance in and for Scotland.

To succeed in persuading Cabinet to allow special provision to be made specifically for Scotland, the Secretary of State for Scotland had still to present a strong case. 'When he could construct a Scottish consensus on social policy he could get his way, providing that the direction he was pursuing did not deviate too far from Government policy in London.'⁶⁵ The Secretaries of State for Scotland between the wars were all men of 'middle opinion'⁶⁶ fostering 'a kind of one-party state ethos bridging businessmen, professionals and collectivists.'⁶⁷ For the state to serve such potentially diverse interests, consensus was essential. The Scottish Office bureaucrats therefore exerted great influence 'since it was by means of their Committees and networks that [the Secretary of State] could sound out and mould Scottish opinion.'⁶⁸

The Cathcart Committee was one of these committees. Its members were not delegates from outside bodies but chosen to ensure the strong consensus required by the Secretary of State in presenting a case for special consideration for Scotland. The Cathcart Committee could also draw on consensus views expressed in previous reports on the development of health services in Scotland –the MacAlister Report in 1920,⁶⁹ the Mackenzie Report in 1926⁷⁰ and the Walker Report in 1933.⁷¹ These reports had made recommendations for the adaptation of British legislation for

⁶⁵ Paterson, op.cit., p. 109.

⁶⁶ Collins was a Liberal in a 'Conservative' Government; Elliot was a nominal Tory; Johnston's radicalism had dissipated before he became Secretary of State.

⁶⁷ C. Harvie, 'Scottish Politics' in A. Dickson and J.H. Treble (eds.), *People and Society in Scotland*, iii (Edinburgh, 1992), p. 247.

⁶⁸ Paterson, op. cit., p. 109.

⁶⁹ *A Scheme of Medical Services for Scotland* (MacAlister Report) 1920, Cmd. 1039.

⁷⁰ *Report of the Hospital Services (Scotland) Committee* (Mackenzie Report), HMSO, 1926.

⁷¹ *Report on the Hospital Services of Scotland* (Walker Report), HMSO, 1933.

application in Scotland. The establishment of a separate bureaucracy and advisory structure for Scotland had not led to a separation of policies. It had ensured that the implementation of British legislation was achieved in Scotland efficiently and in a spirit of co-operation. In reviewing the history of the development of health services for guidance the Cathcart Committee was drawing on experience that was both Scottish and British. That the Cathcart Committee was looking for a new and original policy did not indicate an intention to pursue an independent line for Scotland. It simply reflected the reluctance of the administrations in London during the inter-war years to admit the need for reform.

The Policy and the State

The Cathcart Report stated that the ultimate aim was 'the health of the people' and that the policy to be followed should be 'a positive one and not merely the removal of obstacles to health.'⁷² The humanitarian motive was to remain and be developed with a 'higher degree of responsiveness and a finer sensitiveness, than was conceived by the legislature of the last century.'⁷³ 'However there has been increasingly manifest a conscious concern for the quality of the race.'⁷⁴ Mingled with other motives this concern for the quality of the race had, in the Committee's view, inspired new developments in health care and led to a new conception of health policy. Health, physical fitness and the prevention of invalidity were to be promoted by the state and primarily in the interest of the state.⁷⁵ With this in mind the best means for procuring health and curing disease was to be made available to every citizen. 'Best means'⁷⁶ were at that time only available to the small proportion of the population that could afford to provide the full range of medical services for themselves. A greater part of the population could afford only limited medical care but could also rely for further

⁷² Cathcart Report, p. 26.

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ This phrase has been borrowed from the Sir Bertram Dawson who used it frequently in the years after the war.

help on insurance schemes, club schemes and the services of voluntary hospitals. A section of society was completely dependent on charity or the Poor Law. There was great disparity across society in the deficiencies in 'best means' to be made good by a national health policy. While it was generally accepted that, in principle, government should ensure that every member of the public should have access to whatever medical services were necessary, the extent to which these services should be financed by local or Treasury funds was still to be determined. And while the officials of the Ministry of Health continued to assume that services should be administered by local authorities by the 1930s this was not necessarily the only possibility. For the Cathcart Committee in 1933 it was an open question.

There was also the important question: to what extent would the public welcome government intervention in personal health care? A large section of society had at first disregarded the Maternity and Child Welfare Services and had resented the School Medical Service as an intrusion on privacy. At the beginning of the century it had seemed appropriate that the state should impose only on the poor and the delinquent who made up a recognised social problem group. But the First World War had undermined individual confidence and changed attitudes.⁷⁷ The massive loss of life during the war and the even greater loss in the influenza epidemic that came after it had been suffered by all sections of society. For the great mass of people the 1920s and 1930s were times of continuing uncertainty. During the war years they had come to accept the loss of a degree of personal freedom in return for a share in collective security. (This was perhaps particularly the case in Scotland with its 'penchant for state corporatism as a means to social reform.'⁷⁸) In the Brave New World intervention by the state might be accepted in the expectation of scientific expertise, professional skill and administrative competence.⁷⁹ It is implicit⁸⁰ in the Cathcart

⁷⁷ T.C. Smout, 'Scotland 1850-1950' in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain i* (Cambridge, 1993), p. 210.

⁷⁸ Paterson, op. cit., p. 109.

⁷⁹ Mazower, op. cit., p. 92. The shifting balance between voluntarism and state intervention has been fully discussed by Geoffrey Finlayson in 'Citizen and the State

Committee's brief assessment of the history of state health services that it accepted that it was appropriate in those years that health policy had been dictated by the managers of the country and imposed for the benefit of the nation. It is also implicit in the Report that the Committee assumed that state health services should continue to be paternalistic. Although this issue was not discussed in these terms, it is clear that Cathcart contemplated only a health system that would be continue to be supply led.

In 1933 the Cathcart Committee could assume that the role of the state in health care would increase and that every member of the public would be affected by government health policy. But the nature of the relationship between the state and the individual had to be determined.

The Application of Medical Science

The Cathcart Committee was required to view medical services in the light of modern knowledge at a time of change both in medical science and in the politics of medicine. In the first half of the twentieth century the medical sciences were experiencing a period of shift in priorities and ambitions. The gains in health of the mass of the people had been achieved by engineering rather than medical science. Systems of drainage, water supply and general sanitation had contained the infections that had still been the chief threats to life and health at the middle of the nineteenth century. Surgery had advanced over these same decades. Having been based on little more than a study of anatomy, surgery had benefited from microscopy, the advance in pathology and the assistance of anaesthesia. Medicine, on the other hand, had changed relatively little. The pharmacopoeia was hardly more effective in 1933 than it had been for centuries. Chemistry and the brewing and viniculture industries' interest had led to the isolation of micro-organisms and the understanding of their role in disease.

1914-1949: War, Want and Welfare' in G. Finlayson, *Citizen, State and Welfare in Britain* (Oxford, 1994).

⁸⁰ Since Professor Cathcart left no papers and all papers relating to the Cathcart Committee, other than the Minutes of Evidence, have been destroyed it is only possible to offer conjecture.

For a time the science of bacteriology promised to revolutionise the practice of medicine and bacteriology was studied by rising clinicians such as Edward Cathcart. But by the turn of the century understanding of bacteriology had been of direct benefit to few patients. In 1836 Nathan Rothschild, one of the richest men in the world, had died in Frankfurt of septicaemia following minor surgery in spite of the attentions of a physician specially brought from London; in 1936, Sir Godfrey Collins died in Zurich of septicaemia following minor surgery although he too had the attention of a physician brought from London. Bacteriology was not living up to expectations and Edward Cathcart was not alone in turning from bacteriology to physiology. Even in 1933 when the Cathcart Committee was convened the specific cures and effective medical treatments were still years away. Insulin and diphtheria anti-toxin⁸¹ had come into use but they were regarded only as minor additions to digitalis, quinine and morphine, then the chief items in the small range of helpful but non-curative medicines available in the pharmacopoeia.⁸² For the Cathcart Committee and their contemporaries curative medicine, as we now know it, was still inconceivable. Physiology (including psychology) rather than therapeutics seemed to offer the best option as the basis for progress in medicine. For even the most progressive doctors in the 1930s the emphasis could not be on the cure of disease, but only on its alleviation or, whenever possible, on its avoidance. An ability to control and maintain normality suggested a whole new approach to the practice of medicine. A full understanding of the mechanisms controlling the body made it seem possible that these mechanisms might be manipulated to maintain or restore health. Physiology in the early 1930s was the commanding medical science of the day, occupying the place enjoyed by genetics

⁸¹ The anti-toxin was only effective if given early in the course of the illness; it was rarely available and administered in time.

⁸² Although the early forms of sulpha drugs had been introduced in 1935 they were seldom used because of their side effects. More easily tolerated derivatives, effective against a limited range of bacteria, came into general use after the Cathcart Committee had reported. They were first used in Glasgow in the winter of 1937. *Bulletin of the Royal College of Physicians and Surgeons of Glasgow*, xxix, 2000, p. 13.

in the 1990s. It was therefore appropriate that a committee to advise on medical services in the 1930s should be led by a physiologist and inevitable that the Committee, in planning 'in the light of modern conditions and knowledge,'⁸³ should look to the exploitation of the potentials of physiology.

The Population

The Cathcart Report presented an assessment of the size and constitution of the population to be served by future health services in Scotland. It was not based on any previous studies of the demography of Scotland and was limited to an examination of those aspects of demography that were clearly relevant to health. It was also acknowledged that, for the definitive planning of health services, the assessment was inadequate, leaving certain important questions unanswered.

By quoting William Farr in the first paragraph, the Cathcart Report gave notice of the methods to be used in assessing evidence throughout the Report. Farr was the mathematical genius who, as Compiler of Statistics at the General Register Office in London in the mid-nineteenth century, had introduced the use of statistics that came to transform the practice of public health.⁸⁴ Farr had insisted that *the facts themselves* were of more importance than the personal interpretations of even the most distinguished experts. This view was regarded as an affront to the experts of his time and resented by the medical establishment, barring Farr from any teaching post in London. Although, even in 1933, the medical profession was not yet generally given to the use of statistics, the Cathcart Committee followed Farr's practice, quoting recognised experts only when no statistical evidence was available.⁸⁵

⁸³ Cathcart Report, p. 9.

⁸⁴ He used one of the few working machines ever to be built using the principles of Babbage's Differential Engine. (H. Small, *Florence Nightingale: Avenging Angel* (London, 1998), p. 118.)

⁸⁵ The statistical work for the *Report* was done by A. G. McKendrick and W. O. Kermack of the Research Laboratory of the Royal College of Physicians of Edinburgh and P. L. McKinlay of the Department of Health for Scotland.

Changes in the population were clearly very relevant to the health problems of Scotland. In 1931 the population of Scotland was falling. In the first years of the century this might, of itself, have been a matter of great concern and regarded as evidence of racial decline. At that time, quantity, the total number, was taken as a valid measure of the strength of the population but by the early 1930s there had been a change in emphasis. There was now increasing anxiety about the quality – physical and mental – of the people and it was beginning to be understood that the demography of the population had important implications for the physical and mental health of its members. ‘Changes now occurring in the rate of growth of the population and its distribution, not only between urban and rural areas but also by age and sex, are effecting far reaching changes in the problems of public health.’⁸⁶

From the first Census in 1801 each succeeding Census until 1921 had shown an increase in the population of Scotland. Scotland had shared in the explosion of population that had occurred across Western Europe from the middle of the eighteenth century. But as the nineteenth century progressed into the twentieth the rate of increase in Scotland had tended to slow down. The natural increase in the population declined from 12.4 per thousand in 1870 to 6.3 in 1930 and at the time of the Cathcart review it had fallen further to 5.1 per thousand. This was a reflection of a steady fall in the birth rate from 34.6 per thousand in 1870 to 18 in 1934. But over that period the increase in the population had become less regular due to the fluctuating rate of loss by emigration. In the 1920s the rate of emigration had been high. Since then emigration had slowed dramatically but was still large enough to convert the natural increase of the population into an actual net loss of 39,517 (0.8%) between 1921 and 1931.

From the available evidence Cathcart attempted to forecast the population trends of the future. The trends would be determined by a) the birth rate; b) the death rate; and c) migration. Cathcart was obliged to make crucial assumptions. His first

⁸⁶ Cathcart Report, p. 27.

assumption was that 'by far the most important of these factors is the birth rate. It has now declined to a point at which, leaving migration out of account and assuming no great changes in the death rate, it cannot for any length of time maintain the population at its existing level.'⁸⁷

Whether the falling trend in the birth rate may be arrested, and ultimately reversed, or whether it will continue is a matter of speculation. The answer to be given depends on what may be considered the underlying causes; and these are obscure and the subject of much controversy. It depends also on how far these causes, if ascertainable, may be affected by future events.⁸⁸

The speculation to which Cathcart referred related to a theory, then fashionable, that the fundamental cause of the fall in the birth rate was a decline in men's natural fertility.⁸⁹ Two of Britain's leading experts on fertility gave evidence to the Committee. Their theories were not reproduced in the Cathcart Report but were set out at length in their books. Carr-Saunders,⁹⁰ in *The Population Problem: A Study in Evolution*,⁹¹ postulated that all inherited characters were carried in the chromatin of the sperm and the ova (the germinal constitution) but that these characters were predispositions only and subject to modification (germinal change) by environmental conditions even before the sperm and the ova became available for fertilisation. Professor Crewe⁹² in *Organic Inheritance in Man*,⁹³ disagreed about the nature of germinal change, believing that the inherited characteristics carried in the chromatin could only be affected by the external factors after fertilisation had occurred. But both experts agreed that this ability of the foetus to survive until birth was itself an

⁸⁷ Ibid., p. 28.

⁸⁸ Ibid.

⁸⁹ This was thought by many to be occurring as part of the 'Physical Deterioration' of which the nation's performance in the Boer War seemed to indicate.

⁹⁰ A.M. Carr-Saunders, Professor of Social Science, University of Liverpool.

⁹¹ A.M. Carr-Saunders, *The Population Problem: A Study in Evolution* (London, 1922).

⁹² F.A.E. Crewe, Professor of Animal Genetics, University of Edinburgh.

⁹³ F.A. E. Crewe, *Organic Inheritance in Man* (Edinburgh, 1927), p. 175.

inherited characteristic. Both also agreed that this characteristic was open to influence by external factors at some stage in the development of the foetus. Both Cathcart's expert advisors supported the idea that the falling birth rate was the result of a factor in the environment having an adverse effect on the ability of the foetus to survive. These experts believed that the natural fertility of humans was being gradually eroded by his environment.

In the absence of factual evidence, Cathcart rejected the views of the experts in favour of his own reasoning. First, it was inherently probable that a change in natural fertility, if it was occurring at all, would manifest itself only slowly and cumulatively over a long period of time. It seemed highly improbable that such a change in the nature and constitution of men and women could, in only two generations, account for the fall in the birth rate from 35 per thousand in 1871 to 18 in 1934. Cathcart therefore dismissed a decline in natural fertility as the cause of the decrease in the birth rate.

It was a common assumption in the 1930s that one of the main causes of the fall in the birth rate was an increase in the average age at marriage. At Cathcart's request, this possibility was investigated by Dr. McKinlay, the statistician of the Department of Health for Scotland. He showed that the average age of all persons marrying in Scotland had varied only between 27.3 years in 1861 and 27.8 in 1930 and that there was no correlation between these small changes and the rapid decline in the birth rate.

With no evidence to support changes in natural fertility or in the age at marriage as the explanation, Cathcart concluded that the fall in the birth rate must be attributed to an increasing knowledge and practice of birth control. While this must be the immediate mechanism, Cathcart believed that 'deeper-seated causes are operative, of which the widespread adoption of contraceptive methods are but the outward manifestation.'⁹⁴ Cathcart declined to speculate on any possible political or religious

⁹⁴ Cathcart Report, p. 29.

factors and confined his discussion to economic considerations that might motivate parents to limit their families. The economic motive in restricting family size could be considered either negatively as a careful reaction to economic insecurity or positively as a desire for more material comforts for a smaller number of children.

Cathcart noted that the decline of the birth rate had proceeded for decades through times of relative prosperity and times of depression and in countries unaffected by the revolutions of the trade cycle. Cathcart could find no evidence that family size was either deliberately reduced in times of hardship or increased in better times. The most striking observation was the marked difference in the birth rate between social classes, the highest rates being found in the poorest sections of the community. Cathcart also records that 'it has been a matter of frequent observation that one of the first effects of an improvement in the standard of life is to evoke a desire to maintain that standard, with, as a means thereto, a consequent restriction in the size of the family.'⁹⁵ Cathcart therefore suggests that a continuing general increase in the country's standard of living would inevitably lead to a progressive fall in the birth rate of the poorer classes. Overall the trend towards a decline in the population would continue. The conclusion was 'that the main immediate cause of the low birth rate is deliberate prevention of births, that this cause will probably continue to operate and that for purposes of social policy a continued low birth rate may be assumed.'⁹⁶

Cathcart had less difficulty in reaching a conclusion on death rates. Death rates had declined less dramatically than birth rates, falling from 22.7 in 1871 to 12.92 in 1934. Any appreciable further fall was thought to be unlikely, indeed as the average age of the population increased death rates would probably show some small increase. However 'we may rule out any movement of the death rate in considering future numbers.'⁹⁷

⁹⁵ Ibid., p. 30.

⁹⁶ Ibid.

⁹⁷ Ibid.

Cathcart also ruled out migration (emigration/immigration) as a factor that would materially affect the size of the population. For long periods of the nineteenth century and early twentieth century there had been emigration of large numbers of Scottish people balanced in part by immigration from other parts of the United Kingdom, chiefly from Ireland. Cathcart offered no figures but stated firmly that in the preceding few years this balance had changed. 'There has been some movement of Scottish people to the midlands and South of England, but overseas emigration has practically ceased and the immigration of Irish people has considerably slowed down.'⁹⁸ The return of some emigrants from overseas during the world recession was discounted as a passing phenomenon. Cathcart assumed that in the future migration would not be a substantial factor in modifying the size of the Scottish population although it might have some slight influence tending to diminish rather than increase the population. Based on this assessment of trends in birth rate, death rate and migration,⁹⁹ Cathcart concluded that 'the population of Scotland will almost certainly not expand much further and is likely to decline.'¹⁰⁰

Cathcart forecast that the Scottish population would continue to become more urban. In 1931 a third of the total population already lived in the four large cities of Glasgow, Edinburgh, Dundee and Aberdeen. At the 1931 census over 80% of the population lived in urban areas (57.7% in 1861) and only 20% in the rural areas (42.35% in 1861). 'On the geographical distribution, the salient fact is to be found in the concentration of population in a small part of the total area, namely in the industrial belt between the Forth and the Clyde with strips of lower density along the

⁹⁸ Ibid.

⁹⁹ Cathcart quotes but does not endorse calculations published by G. C. Leybourne, a research student of the Department of Social Science of the Liverpool University in the *Sociology Review* for April 1934. This study assumes that the proportion of women between 15 and 45 who are married will remain constant, that the death rate will continue as at 1924-1932, and that the birth rate will not continue to fall beyond 1944. On this basis the population of Scotland is predicted to peak at 4,969,800 in 1941 falling thereafter, at first slowly but more quickly after 1970 to reach 4,055,300 in 1970.

¹⁰⁰ Cathcart Report, p. 31.

east and south-western coasts.' Cathcart did not accept that this was necessarily a threat to health in 1936. 'There is not now the discrepancy that used to exist between the health of the town and the country. The great sanitary improvements, above all by a plentiful supply of water and by sewerage, have chiefly affected the towns, and the experience has demonstrated that those elements in an urban environment that are harmful can to a large extent be removed or 'neutralised.'¹⁰¹

Cathcart, while not worried by increasing urbanisation, feared that Scotland was facing the reciprocal problem of depopulation. This was most obvious in the Highlands and Islands where the population of the area served by the Highlands and Islands Medical Service had fallen by 14.6% between 1911 and 1931. In 1936 the depopulation of certain areas of Scotland was 'now raising acutely the question of the capacity of the area to provide, through the present units of administration and from present financial resources, the services that are demanded by modern standards.'¹⁰²

The increasing proportion of old people in the population promised further difficulties. The average age of the population had increased from 26.5 years in 1861 to 31.3 in 1931. While the proportion of those in the 'early years of industrial life' (15 – 45 years) had remained almost constant (44.4%- 45.6%) the proportion of younger people had fallen from 36% to 27% and of those older than 45 years the proportion had risen from 19% to 28%. Since the increase in the average age of the population had been increasing since the period 1881-1891 and the increase had accelerated since then, Cathcart concluded the 'it may be assumed that the proportion of older people will increase and the average age rise correspondingly.'¹⁰³ It was forecast that the broad effect would be that the diseases of later life would come to represent a larger and those of the earlier life a smaller proportion of the sum-total of the diseases of the whole population. This would undoubtedly affect health policy and would have a

¹⁰¹ Ibid.

¹⁰² Ibid., p. 36.

¹⁰³ Ibid., p. 32.

profound effect on 'the outlook of medicine'.¹⁰⁴ The fact that people were living longer would increase the overall demands on personal and domiciliary services as the people made increasing efforts to maintain fitness throughout a longer span of years. Hospital services would also be affected as more and more institutional facilities were required by a growing number of old people. 'The increased numbers who survive to the later ages of life have made this problem of the aged, whether in health or in sickness, one of the dominant factors in the provision of general hospitals, mental hospitals and public assistance.'¹⁰⁵

The increasing age of the population was expected to continue to affect the sex ratio (females/males) of the population. This had remained almost constant at around 1.08 in the fifty years before 1931 showing only slight falls during wars and at times of high emigration. However, as a consequence of the disproportion of the number of women surviving into old age the sex ratio had shown some increase particularly in the older age groups; in the age group over 85 there were already two women for every man. However Cathcart took the view that 'the sex ratio is probably not a matter of fundamental importance for health policy.'¹⁰⁶

Cathcart's assessment of trends in population was entirely credible in the circumstances of the first half of the 1930s. But these forecasts made in the early 1930s were of little help in the planning of medical services in the later 1930s and 1940s. The population of Scotland had already begun to increase even while the report was being prepared. Between 1933 and 1938 the population increased by almost 2%. The increase continued to 5% in 1948. Before the population began to decline in the 1960s the population was 6.5% greater than when the Cathcart Committee was appointed.¹⁰⁷

¹⁰⁴ Ibid., p. 36.

¹⁰⁵ Ibid..

¹⁰⁶ Ibid., p. 33.

¹⁰⁷ Figure calculated from the *Annual Reports of the Registrar General for Scotland*.

As forecast by Cathcart, the death rate played little part in these changes, falling steadily from 13.2 in 1933 to 12.3 in the 1960s. Birth rates were more important. During the poverty and unemployment, at its worst in Scotland between 1931 and 1933, it was poverty rather than increasing prosperity that reduced the birth rate to 17.6 in 1933 and 16.3 in 1934. The subsequent improvement in the economy was followed by a slow rise in the birth rate to 17.8 in 1938, an increase which continued to 19.4 in 1948. The natural increase in the population from these changes should have been 0.44% in 1933 rising to 0.76% in 1948.¹⁰⁸ However this natural increase did not result in a corresponding rise in the actual population. Cathcart had been wrong to assert that 'migration may be ruled out as a factor materially affecting population.' Emigration had indeed almost completely stopped during the 1930s while the Great Depression in North America closed employment opportunities to potential emigrants from Scotland. The Depression in the United Kingdom similarly had a similar effect in inhibiting migration to the south. But after Cathcart had reported, the recovery in the economy both in North America and in the United Kingdom revived both emigration and migration from Scotland. Between 1931 and 1951 net emigration/migration reduced the natural increase of the Scottish population by 49.6%. This was a modest figure compared with what was to come in later decades (Table 1).

¹⁰⁸ Ibid.

Table 1.

**Net Migration as a Percentage of Natural Growth,
Scotland 1901-1990**

1901-11	- 46.8
1911-21	-66.2
1921-31	-111.2
1931-51	-49.6
1951-61	-75.6
1961-71	-85.6
1971-81	-267.7
1981-90	-468.7

Source: *Annual Report of the Registrar General for Scotland*, 1990, p 107.

In spite of its obvious implications Cathcart did not discuss the decline of the relative size of Scotland's population. This was already apparent in the 1930s (Table 2).

Table 2

Population of Scotland, England, and Wales as Percentage of UK Population.

	1901	1921	1931	1951	1961	1971	1981
Scotland	12.1	11.4	10.8	10.4	10.1	9.7	9.5
England	82.5	82.3	83.4	84.3	84.7	85.3	85.5
Wales	5.4	6.2	5.7	5.3	5.2	5	5.2

Source: M. L. Tranter, *British Population in the Twentieth Century* (London, 1996).

The Report recognised that 'in submitting proposals that involve increased expenditure from the rates and increased contributions from insured persons, we are conscious that these, as sources of additional income for public service, are nearing

exhaustion.’¹⁰⁹ Although services would undoubtedly be financed increasingly by Imperial taxation and the changing size of Scotland’s population in relation to that of the United Kingdom had clear implications in determining Scotland’s proper share of imperial funds, this issue was not discussed in the Cathcart Report.

Cathcart accepted the urbanisation of Scotland would continue. Anderson¹¹⁰ has demonstrated that was indeed the case. Since 1931, apart from the creation of Glenrothes, the distribution of the people was changed only by the continuing movement from the rural areas and the expansion of existing towns. Where there had been some apparent evidence of rural increase it ‘turns out on close observation to be involve expansion of single towns within parishes dominated by rural depopulation.’¹¹¹ In the process of expanding Scottish towns were becoming more ‘rural.’ This was further evidence in support of Cathcart’s contention that urban living was no longer to be regarded as necessarily a hazard to health.

Cathcart was also proved to be correct in his prediction of an ageing population. In 1961 the proportion of the population in ‘the early years of industrial life’ had fallen to 34.2% (45.6% in 1931) and those younger than that age to 27.6%. Those over 45 years of age now formed the largest proportion at 38.2% (28% in 1933). The effect of this change on the cost of medical services is complex and will be discussed in a later chapter. It will be shown later that the proposition that the ageing of the population would necessarily result in an increase in the cost of medical service was not as certain as assumed by Cathcart.

Overall Cathcart’s assessment of the demographic changes to be expected in Scotland were only correct in very general terms and were not reliable as a guide to the planning of future health services. Given the changes that took place in society as

¹⁰⁹ Cathcart Report, p. 276.

¹¹⁰ M. Anderson, ‘Population and Family Life,’ in *People and Society in Scotland*, (eds.) A. Dickson, and J. H. Treble, op.cit.

¹¹¹ *Ibid.*, p. 16.

the Scottish economy unexpectedly began to recover in the late 1930s and in the unforeseeable circumstances of a Second World War this seems inevitable.

However in a Report setting out a policy specifically for Scotland which frequently referred to the differences in health standards between Scotland and England/Wales, it is surprising that Cathcart did not draw attention to the difference in the demographic system operating in Scotland from that operating south of the border.¹¹² Demography is determined by the fertility of a population, balanced by the loss through death and the net effect of migration / immigration. Nuptuality is no longer considered to be important. It has become clear that fertility of a population is not related to the number of marriages but rather to fertility within partnerships.¹¹³ As the proportion of children born outside marriage increased (eventually to 27.1% in Scotland in 1990) nuptuality became totally irrelevant.¹¹⁴ Although there are more sophisticated methods of measurement¹¹⁵ the crude birth rate is now accepted as an adequate indication of trends in levels of fertility.¹¹⁶ Systems of demography may be studied only in terms of birth rate, death rate, and net migration. In these terms Scotland, from the beginning of the century until the 1960s has had a different system from that in England and Wales (and different from most western European countries). Scotland has had a 'high pressure' system with birth rates and death rates consistently higher than in England and Wales producing a higher natural increase. However in Scotland, this potential increase in the population was diminished by the net effect of migration/immigration that reduced the natural increase by 49.6% in the period from 1931-51 and by 76.6% between 1951 and 1961. This was in stark contrast with the situation in Great Britain as a whole where net migration/immigration added

¹¹² Cathcart Report, p. 31.

¹¹³ Ibid. p. 12.

¹¹⁴ N. L. Tranter, *British Population in the Twentieth Century* (London, 1996), p. 89.

¹¹⁵ For example, the Total Fertility Index used by W. Brass in H. Joshi (ed.), *The Changing Population of Britain* (London, 1989).

¹¹⁶ Tranter, op.cit., p. 83.

15.2% to the natural increase of the population between 1931 and 1951 and by 5.1% between 1951 and 1961.

Cathcart's predictions for the demography of Scotland, based on factors operating in the 1930s, were understandably inaccurate and gave no more than very general indications for the planning of health services in Scotland. But Cathcart did make it clear that in planning health services, monitoring the size, distribution and dynamic of the population would be essential.¹¹⁷ In presenting population figures for Scotland, Cathcart had already shown that the demography of Scotland has a dynamic of its own.

Conclusion

The Cathcart Committee began its search for a modern health policy in a British context. It had been convened as a consequence of an economic depression that affected Britain as a whole. The depression divided England and Wales; while the larger part was able to maintain a degree of prosperity the full effects were felt in the centres of the declining heavy industries. The Ministry of Health was able to present an overall picture of the health of the England and Wales in which the threat to the health in the industrial north and west was more than balanced by the continuing well-being of the people of the south east. In the circumstances the government felt justified in avoiding costly investment in extended health services.

In Scotland the depression, with its damaging effect on health, differed both in its severity and in its extent. In Scotland there was no prosperous area to balance the distressed. The effects of the depression on the well being of the people was visible everywhere. The failure of the existing health services to meet the problems of the 1930s was obvious and acknowledged by the Department of Health for Scotland.

The Cathcart Committee was appointed by Scotland's devolved welfare bureaucracy to assess the extent of the problem and to devise a policy that would

¹¹⁷ Cathcart Report, p. 36.

protect and promote the health of the people in the future. In planning for the future the Committee was bound to make certain assumptions. The Cathcart Committee assumed that the provision of state health service would continue to be dictated by government and would therefore be supply led. However the publication of the Beveridge Report in 1942 and government's acceptance of its proposals made it inevitable that the future provision of health services would be shaped by the demands of the public. Within a few years that demand would be enormously increased by the revolution in medical treatment, a revolution which, to many, seemed to make the disciplines of Cathcart's scheme for prevention unnecessary. The Cathcart Report proved to be wrong in its assessment of the extent of demands that would be made of the health services of the future and it failed to recognise that changes in the demography of Scotland, quite different from those in England and Wales, would have implications for Scotland's share of the Treasury funds allocated for health. In some certain important respects, the Cathcart Report was to be overtaken by events. But in Britain between the wars it was the best there was.

CHAPTER FOUR

SOCIAL CONDITIONS AND HEALTH

In the 1930s social conditions and health had again become national issues. A hundred years before, the diseases bred in the appalling ghettos of growing industrial centres were a danger to the health of the whole community. This threat, the most immediate and pressing social problem of the time, was contained as public health measures were introduced in the second half of the nineteenth century. In the first years of the new century there was a new focus of anxiety. In the aftermath of the Boer War, Britain suddenly seemed less secure. It was feared that the nation's military and economic pre-eminence was being undermined by the failing fitness of the mass of the people, increasingly bred in urban squalor. The state introduced new financial support for the elderly and the casualties of industry. New schemes were introduced to promote the growth and development of sound infants and to ensure the continuing fitness of the workers in the country's key industries. But in the economic depression of the 1920s and 1930s it was no longer only the perennial dependent minority – the young, the sick, the disabled, the elderly and the destitute – who were in need of protection by the state. Much of the main active body of the country's population were now unemployed and poverty was added to long-standing deficiencies in their living conditions. How effectively the victims of the Depression were being protected by state welfare schemes set up in previous decades, was a matter of dispute. The government could see no pressing need for massive investment in new social security programmes at a time of particular financial difficulty; but to large sections of the public the need seemed undeniable.

In the depths of the economic depression, the Cathcart Committee had been appointed to look for economies and to find ways in which the existing health services in Scotland could be made more efficient. Over three years the Committee had turned the focus of its attention from the crisis situation of 1933 to planning for the long-term

future of health services in Scotland, and by implication in Britain. The Committee was preparing a new policy for health that would require the support of the government, and all those currently involved in health care. The Committee therefore attempted to distance itself, as far as was possible, from the current controversies over the true effects of the Depression on the welfare of the people¹ and the damaging rivalries, particularly in London, between the local authority and the voluntary medical services in England and Wales.²

The Report offered only a brief account of social conditions as they were in the 1930s. Of a total of eight pages, four were completely taken up by the personal views of only six witnesses. This was a remarkable and significant deviation from practice followed elsewhere in the Report. Early in the Report, the Committee had indicated that it would rely as far as possible on statistical evidence, accepting opinion, no matter how expert, only when no hard evidence was available. By describing the social conditions of Scotland briefly and in general terms it avoided potentially embarrassing involvement in controversies that it hoped would be irrelevant to its plans for the future.

By taking the long view the Cathcart Committee was also able to present social conditions in Scotland in a favourable light. In a hundred years, Scotland had advanced from 'insanitary squalor to decency.'³ As the stimulus for this very satisfactory improvement the Committee identified the evidence submitted to the Poor Law Commissioners in 1842:

The general impression left, after reading these reports, is that, among informed people of the time, there was serious alarm over the widespread physical and moral deterioration that was taking place and

¹ C. Webster, 'Healthy or Hungry Thirties?' *History Workshop Journal*, xiii, 1982, p.111; F. Honigsbaum, *The Division in British Medicine* (London, 1979).

² Some degree of co-operation had been achieved in Liverpool, Manchester, Sheffield and Oxford. G. Finlayson, *Citizen, State and Social Welfare in Britain* (London, 1994), p. 240.

³ Cathcart Report, p. 37.

that poverty and lack of sanitation were regarded as primary and interacting causes.⁴

Since then, the standard of living and the habits of the Scottish people had been transformed. The Report briefly acknowledged the vital part played by the sanitation schemes - drainage, sewerage and water supply - put in place in the nineteenth century. At greater length the Report gave particular credit to the relief of poverty, recalling the observations of Professor W. P. Alison⁵ and Professor Robert Cowan⁶ who had accompanied Chadwick on the inspections carried out by the Poor Law Commissioners.⁷ Alison, in his *Observations on the Management of the Poor*,⁸ had attributed the appalling living conditions discovered by the Commissioners to 'pauperism, or destitution worse than pauperism, which had demanded relief but had failed to find it.'⁹ He had concluded that this poverty was

not only much greater in Scotland than in any other European countries similarly situated, but that it was greatly increasing, and that this increase, together with the influx of rural and Irish pauperism into our great towns, had brought them into a condition greatly more favourable than they had ever been before to the spread of epidemic disease, and accordingly raised their mortality far above the level of corresponding towns in England or the Continent.¹⁰

Robert Cowan, in a paper read to the British Association in 1840, had observed that 'the prevalence of epidemic disease depends upon various causes but the most influential of all is poverty.'¹¹ These views did not find favour in 1842 but Cathcart

⁴ Ibid, p. 39.

⁵ Professor of Medicine at Edinburgh University.

⁶ Professor of Medical Jurisprudence and Medical Police at Glasgow University

⁷ The Report made no reference to the controversy at that time between Chadwick and those who attributed urban disease to miasma and the breathing of foul air and Alison and those who believed that poverty was the chief cause.

⁸ Cathcart Report, p. 38. This and the quotations in the following two references paraphrase Alison's views but are not direct quotations from W. P. Alison, *Observations on the Management of the Poor in Scotland* (Edinburgh, 1840).

⁹ Cathcart Report, p. 38.

¹⁰ Ibid.

¹¹ Ibid.

believed that, over the years, Alison and Cowan had been vindicated. In the 1850s wages in Scotland had remained low and the cost of living relatively high. Women and children, from the age of seven or eight, were employed in the mines for 10 or 12 hours a day. Accidents in the workplace were common and in the absence of legislation for workmen's compensation or social insurance there was no organised assistance for the unemployed. Poor relief, the only form of public assistance, was scanty and uncertain. Cathcart noted that since then

the standard of living has risen and, apart from increases in real wages, the minimum standard of subsistence below which the community does not allow any of its members to fall is higher than any previous time and certainly much higher than during the last century. A wide range of social services – workmen's compensations, health and employment insurance, widow's and old age pensions, public assistance, etc – has abolished destitution as it was understood and described in the Sanitary Inquiry Reports of 1842.¹²

The working environment had also improved. Industrial machinery had reduced the wear and tear of physical exertion. Leisure time had increased and public transport had made it possible for workers to live at a greater distance from their place of work. The development of transport had also brought a greater range of food and other commodities within the reach of the people. Increased leisure time had encouraged the 'cult of gardening and facilitated all kinds of open- air recreation.'¹³ Gas lighting had reduced the risk of accidents at home and in the streets. Electric power had created a healthier atmosphere by reducing the burning of coal. Extended education, reinforced by the influence of the cinema and wireless broadcasting, had changed the outlook of the people, heightening their 'capacity and...will for healthy living'.¹⁴

As evidence that health had indeed improved as a result of these changes, the Cathcart Committee pointed out that 'in 1855, out of every 1000 persons born in

¹² Ibid, p. 41.

¹³ Ibid, p. 42.

¹⁴ Ibid.

Scotland, 240 died before the age of five years compared with 117 in 1934.¹⁵ As evidence of a new and more enlightened life style it was noted that the number of court convictions for drunkenness had decreased; one witness had assured the Committee that 'alcoholism has decreased enormously ... delirium tremens is never seen and the sequelae of chronic alcoholism are rarely found.'¹⁶ Cathcart concluded

that the social and economic background has changed so as to allow immeasurably greater possibilities of healthy living for the mass of the people, that the habits of the people from whatever cause or combination of causes- improved sanitation, higher standard of living, more general education, quicker communications, increased and more varied facilities for recreation and so on- are in fact healthier.¹⁷

On the very limited evidence it had solicited the Cathcart Committee felt able to make an optimistic projection of future trends:

Improvement in working and living conditions during the period of greatest development of the health services has combined with the results of these services to produce changes in the health of the people, their habits and outlook, and in the problems of health policy and organisation. ..Changes...have occurred or are still in progress, for example, in diet, in leisure and recreation, in housing, in severity of labour and in working conditions, and so on. The sum-total of these changes, viewing them together, has altered the general attitude and outlook of the people in ways that are specially significant for health policy.¹⁸

It was acknowledged that 'no witness suggested that there was not great room for improvement'¹⁹ but the Cathcart Committee was confident that, as a result of many years of improvement in social conditions, in Scotland in the 1930s, 'health is prized' and the people prepared to 'lead ascetic lives' to preserve it.

¹⁵ Ibid, p. 39.

¹⁶ Ibid, p. 44.

¹⁷ Ibid, p. 45.

¹⁸ Ibid, p. 37.

¹⁹ Ibid.

It was only by taking the long view that the Cathcart Committee could be so confident about the attitudes of the public and so optimistic about a continuing progress towards health living. Those who were more focused on the immediate problems of the 1930s were far from unanimous in sharing this confidence.²⁰ In *The Condition of the Working Class in Britain* the Communist Harry Pollitt wrote that 'in 1933, for the mass of the population, Britain is a hungry Britain, badly fed, badly clothed and badly housed.'²¹ This bleak assessment was repeated to a very much wider audience by other commentators and famously by George Orwell in *The Road to Wigan Pier*.²² Some historians have since claimed these and other similar accounts were prejudiced and that the 'Hungry Thirties' was 'a myth sedulously propagated.'²³ The extent to which England suffered during the Depression has since been briskly debated.²⁴ The government of the time, however, was confident that the economic crisis of the 1930s was no more than a passing phenomenon during which the health and strength of the people were being well protected by the state. In the House of Commons on 17 July 1935 the Minister of Health, Sir Kingsley Wood, presenting a triumphant review of the achievements of his ministry in 'this Jubilee year', claimed that never had 'medicine made such strides as in the last twenty five years' and at the same time 'the nation itself has learned and is learning today, in many ways, the supreme art of Living.'²⁵ Again in 1935, the Prime Minister, Stanley Baldwin,

²⁰ As a Cambridge student, Dr. Reg. Passmore gave first aid to hunger marchers at this time. He remembers that this experience greatly influenced his attitude to the practice of medicine as well as to his politics. Recorded interview.

²¹ H. Pollitt, Introduction to A. Hutt, *The Condition of the Working Class in Britain*, (London, 1933).

²² G. Orwell, *The Road to Wigan Pier* (London, 1937).

²³ C. L. Mowatt, *Britain Between the Wars* (London, 1968), p. 432.

²⁴ That the 'myth' was false- Mowat, op.cit; D. H. Aldcroft, *The Interwar Economy in Britain*, (London, 1970); J. Stevenson and C. Cook, *The Slump* (London, 1974); J. M. Winter, *The Great War and the British People* (London, 1986). That the distress of the 1930s was real – C. Webster, 'Healthy or Hungry Thirties?' *History Workshop Journal*, xiii, 1982, p. 110; C. Webster, 'Health Welfare and Unemployment During the Depression,' *Past and Present*, cix, 1985, p.204; L. Bryder, *The First World War; Healthy or Hungry*, *History Workshop Journal*, xxiv, 1987, p. 139.

²⁵ *Hansard*, ccciv, HC, 15 July 1935, col. 1061.

reassured a concerned public that the social services were proving 'wonderfully well maintained',²⁶ and fully effective. His claim was fostered by the Ministry of Health. In 1930 the Minister of Health had commissioned surveys of state medical services 'to satisfy himself that the Local Authorities were achieving and maintaining a reasonable standard of efficiency and progress in the discharge of their functions relating to public health services.'²⁷ In a preliminary survey, visiting Medical Officers from the Ministry of Health had found no 'cause for criticism' and were 'able to select for special commendation the high quality of the work being carried out by particular services.'²⁸ By 1934 the surveys of all the local authority areas in England and Wales had been completed and there was no retreat from this early favourable judgement. The Ministry had satisfied itself that the re-organisation of services following the Local Government Act of 1929 had been eminently successful and their new effectiveness had been 'nowhere more strikingly illustrated than in London, and nowhere upon so great a scale.'²⁹ The Ministry was able to show that, although the numbers included in the National Health Insurance Scheme had risen steadily, the total amount of support required had fallen.³⁰ Reports on housing were also satisfactory. In 1931 the Ministry reported that there was no overall shortage of houses in England although there was a need to 'replace houses that ought to be demolished.'³¹ A scheme was launched to build 300,000 to replace the slums.³² By 1935 the Ministry was able to report that since the end of the war, apart from slum clearance schemes, 1,213,397 low cost houses³³ had been built in England with state assistance.³⁴ Less reassuring was the report that the numbers receiving aid under the

²⁶ PRO MM 55/688 quoted by C. Webster, 'Health, Welfare and Unemployment During the Depression,' op.cit., p. 204.

²⁷ *Annual Report of the Ministry of Health, 1931-32*, Cmd. 4113, p. 43.

²⁸ *Ibid*, p. 44.

²⁹ *Annual Report of the Ministry of Health 1934-35*, Cmd. 4978, p. 95.

³⁰ From £29,231,000 in 1929 to £25,637,000 in 1934. *Annual Report of the Ministry of Health 1934-35*, p. 329.

³¹ *Annual Report of the Ministry of Health 1931-32*, p. 96.

³² *Annual Report of the Ministry of Health 1934-35*, p. 147.

³³ Rateable value less than £78.

³⁴ *Annual Report of the Ministry of Health 1934-35*, p.157.

Poor Law had increased by 64% between 1930 and 1935³⁵ suggesting that there had been some increase in poverty. However there was no proof that this had resulted in hunger or malnutrition; in 1935 the Ministry had resolved its differences with the BMA on the requirements of calories and protein to maintain normal life³⁶ but no survey had been carried out to discover how far these agreed standards were being met.

On the evidence of the surveys of local authority health services, the reduced demand on the National Insurance scheme, a falling Infant Mortality Rate, fewer deaths from tuberculosis and infectious diseases generally, the lowest ever corrected death rate of 9.3 and a sound housing program, the Ministry concluded that England was enjoying a period of 'very signal development and improvement in many directions, valuable in themselves and so conceived as to lay sound foundations for the future.'³⁷

While the Ministry of Health in London was reassuring government ministers and denouncing local reports of poverty and ill health as 'socialistically motivated stunts',³⁸ the Department of Health for Scotland was taking a very different line. 'There are gaps and flaws in our health services and medical imperfections that are only now being thrown into prominent relief.'³⁹ In 1932 the Department called for 'comprehensive reform of the whole system of dealing with the effects of unemployment',⁴⁰ and recommended 'radical changes',⁴¹ in the country's health services. The Department therefore welcomed the appointment of a Committee to review health services in Scotland.⁴²

³⁵ From 720,547 in June 1930 to 1,183,166 in March 1935.

³⁶ *Annual Report of the Ministry of Health 1934-35*, p. 137.

³⁷ *Ibid.*, p. 14.

³⁸ Webster, 1982, *op. cit.* p.112.

³⁹ *Annual Report of the Department of Health for Scotland*, 1935, Cmd. 5123, p.21.

⁴⁰ *Annual Report of the Department of Health for Scotland*, 1932, Cmd. 4338, p.12.

⁴¹ *Ibid.*

⁴² *Ibid.*

The Cathcart Committee no doubt fully shared the Department of Health's appreciation of the situation but, as we have seen, wished to avoid impolitic confrontation with the administration in London. Nevertheless, it did allow that in 1917 the Royal Commission on Housing had been able 'to point to much poverty, bad working conditions, slums and overcrowding although to nothing quite so gross as any of typical conditions described in the reports of the first half of the last century.'⁴³ The Committee accepted that there was a danger that 'people at large may come to accept as a matter of course the sanitary achievements of these latter days and may fail to realise how recently that standard has been attained and how necessary it is to maintain them at their full efficiency.'⁴⁴ By going no deeper into the poverty and poor living conditions in Scotland, the Cathcart Committee failed to emphasise how much urgent improvement was still required attention or to explore what were the fundamental causes of Scotland's persistently bad record of health.

A Long Term Problem in Scotland.

In Scotland there was little confidence that the social and economic misery of the 1930s was a passing phenomenon. Commentators at the time saw little prospect of industrial recovery in Scotland.⁴⁵ The heavy industries of Scotland's Economic Miracle had been in decline since the end of the First World War and in the mid 1930s there were still no signs of any new industrial activity which might stimulate an economic recovery. The loss of income and hardship, that had accompanied the decline in the economy over more than a decade, had been exacerbated by the massive unemployment of the Depression. In the House of Commons Walter Elliot described Scotland's cities as 'heaped up castles of misery.'⁴⁶ The misery was not confined to

⁴³ Ibid., p. 40.

⁴⁴ Ibid.

⁴⁵ The distress of the times was described, among others, by J. Boyd Orr, in A. Macle hose (ed.), *The Scotland of Our Sons* (London, 1937); J. A. Bowie, *The Future of Scotland* (Edinburgh, 1939).

⁴⁶ Walter Elliot quoted in Macle hose, op.cit.

the cities but was widespread and severe across the country. Edwin Muir wrote of his journey through Scotland in 1934:

My impression was one of emptiness, and that applied even more to the towns than the countryside. Scotland is losing its industries, as it lost over a hundred years ago a great deal of its agriculture and most of its indigenous literature...Now Scotland's industry, like its intelligence before it, is gravitating to England, but its population is sitting where it did before, in the company of disused coal-pits and silent shipyards.⁴⁷

The industrialisation of Scotland had left 'its mark on several generations of men women and children by whose work it lived, in shrunken bodies and trivial and embittered minds.'⁴⁸ The statistical evidence of the effect of poverty and dreadful living conditions was reported year by year by the Department of Health for Scotland. There was less formal, but equally persuasive, evidence in the records of the Church of Scotland. In many parishes as many as 60% of church members were unemployed. The Church was particularly disturbed by the effects of unemployment and poverty on the urban population of Scotland (80% of the whole), and could see 'little hope of any speedy progress being made towards the solution.'⁴⁹ The Church saw no evidence of that heightening of the 'capacity and will for healthy living'⁵⁰ reported by Cathcart. Cathcart had given a decline in alcoholism as evidence of an improvement in life style. Cathcart had offered anecdotal evidence and there was some statistical evidence that, at first sight, might seem to support this claim. Over the year 1931-32 the consumption of spirits in Scotland had decreased by 946,000 gallons and beer by 3,370,00 gallons and total spending on licensed alcohol sales by 10.5%.⁵¹ The Chief Constable of Glasgow reported that 'drunkenness *as ordinarily understood* showed a decided decrease.'^(my italics) However 'the number of persons proceeded against for drunkenness produced by drinking methylated spirit has increased.' Methylated spirit

⁴⁷ E. Muir, *Scottish Journey* (2nd ed. Edinburgh, 1996), p. 243.

⁴⁸ *Ibid.*, p. 42.

⁴⁹ *Reports to the General Assembly of the Church of Scotland*, xiv, 1934, p. 465.

⁵⁰ Cathcart Report, p. 42.

⁵¹ *Report to the General Assembly of the Church of Scotland*, op.cit., p. 502.

could be bought surreptitiously from street vendors for a few pennies and in the 1930s Scotland's Chief Constables had come to recognise 'meths' drinking as a serious menace.⁵²

In presenting a somewhat benign view of social conditions in Scotland the Cathcart Committee was being circumspect.⁵³ It must be assumed that the Committee wished to avoid unnecessarily harsh criticism of the bodies and services whose co-operation it wished to enlist. It may also have been judged politic to avoid open contradiction of the Government's recent confident assessments of the state of the nation.⁵⁴ The picture painted by the Department of Health for Scotland, the Church of Scotland, Edwin Muir and Walter Elliot is more convincing and more in accord with my own experience, both in the 1930s and again in the early years of the National Health Service. The continuing problems of poverty, poor diet and bad living conditions – the worst features of urbanisation – were all too evident in the 1930s and their legacy has not yet disappeared. The relative severity of these problems was one of the factors that led to differences in practice in the NHS in the different part of Britain.

Urbanisation

Studies have shown that since the urbanisation of the Minoan and Mycaenian people in the Bronze Age,⁵⁵ while the elite remained unscathed by urbanisation the poor became shorter and less heavily built and suffer a shortened life span. The urbanisation that accompanied the Industrial Revolution in Britain had produced people smaller than their grand parents and with an average life span shorter than in

⁵² Ibid., p. 556.

⁵³ All papers relating to the Cathcart Committee were destroyed during the Second World War and Professor Cathcart left no papers of his own. The comments on the considerations that shaped the Committees decisions can only be speculative.

⁵⁴ *Hansard*, cclxxx, HC 7 July 19.33, col. 656

⁵⁵ W. J. MacLennan and W. I. Sellars, 'Ageing Through The Ages', *Proceedings of the Royal College of Physicians of Edinburgh*, xxix, 1999, p. 72.

the first century BC.⁵⁶ In Scotland where urbanisation was ‘abrupt and swift’,⁵⁷ the effects were particularly severe and reached a nadir in the first decades of the nineteenth century.⁵⁸ The changes in physique that occurred over the following 100 years were therefore not ‘improvements,’ as described by Cathcart, but the restoration of normality.

The first phase of the Industrial Revolution in Scotland, the years from c1760 to c1830, formed a ‘bridge between the Old World of rural Scotland and the urbanised society of the later nineteenth century.’ By the 1840s, 40% of the Scottish population already lived in towns of over 5,000 inhabitants⁵⁹ and life in rural Scotland was becoming ever harder. On average, agricultural wages had increased slightly but they had not always kept pace with the inflation of the last years of the eighteenth century and the first two decades of nineteenth century. When prices fell after 1820 agricultural prosperity suffered and the depression soon filtered through from the farmers to their labourers.⁶⁰ Real wages in the 1840s were therefore lower than they had been before the Napoleonic Wars and there was less opportunity to supplement low wages by earnings from outworking in textile production. Rural housing was primitive. The typical farm labourer’s house of the period was described as

about 12 feet by 14, and not so high in the wall as will allow a man to get in without stooping...without ceiling, or anything beneath the bare tiles of the roof; without a floor save the common clay; without a cupboard or recess of any kind; no grate but the iron bars which the tenants carried to it, built up and took away when they left it; with no

⁵⁶ A study in 1994 produced evidence that the median life span in the period 1850 to 1899 was shorter than in the first century BC. J. D. Montagu, ‘Length of Life in the Ancient World,’ *Journal of the Royal Society of Medicine*, dxxxvii, 1994, p. 25.

⁵⁷ T. M. Devine, ‘Urbanisation,’ in T. M. Devine and R. Mitchison (eds.), *People and Society in Scotland* i (Edinburgh, 1988), p. 31.

⁵⁸ As has been discussed in Chapter One the rural population of the Highlands and Islands retained their physical stature and longevity through these years.

⁵⁹ Between 1831 and 1861 less than 40% of the population lived in settlements of more than 5,000. R. J. Morris, ‘Urbanisation and Scotland,’ W.H. Fraser, and R. J. Morris, *People and Society in Scotland* ii (Edinburgh, 1995), p. 74.

⁶⁰ E. Royle, *Modern Britain* (London, 1987), p. 157.

partition of any kind save what the beds made; with no window save four small panes on one side.⁶¹

In the towns and cities living conditions were becoming even harsher. By 1850 the proportion of the population living in towns had risen to almost a third and as an urbanised society, Scotland was second only to England in Europe. The growth of the industrial centres across the central belt was fed by the migration of poor young adults from the rural Lowlands, with small numbers from the Highlands and a flood of both Protestant and Catholic immigrants from Ulster and southern Ireland.⁶² As both a major port as well as a major industrial centre, Glasgow experienced the effect in full. Thousands of power looms served a thriving textile industry. More than a hundred pig-iron furnaces produced hundreds of thousands of tons each year. Ships trading with North America and the West Indies were berthing in increasing numbers at the Broomielaw. Glasgow's first railway opened for traffic in 1831.⁶³ The Clyde was polluted as industrial activity increased and became an open sewer. Disposal of human and industrial waste was grossly defective; cattle were slaughtered in the street; the older parts of the city became increasingly filthy.⁶⁴

'While the higher ranks in Glasgow were advancing in wealth and luxury, a large proportion of the lower rank were receding towards barbarism.'⁶⁵ Housing conditions were appalling. The crowded tenements in which the working classes lived were owned by a large number of the middling classes intent on making a profit. An uncontrolled building boom, beginning in 1831, continued well into the 1870s. Large houses were partitioned and subdivided and shoddy new dwellings sprang up in their

⁶¹ A. Somerville, *The Autobiography of a Working Man* (London, 1848), p. 10.

⁶² B. Collins, 'The Origins of the Irish Immigration to Scotland in the Nineteenth and Twentieth Centuries,' in T. M. Devine (ed.), *Irish Immigration and Scottish Society in the Nineteenth and Twentieth Centuries* (Edinburgh, 1991), p. 1.

⁶³ Glasgow and Garnkirk Railway.

⁶⁴ Butchers were much to blame. In the previous century 'slaying and bluiding the whole bestial they kill on the High Street in Trongait on baith sides of the gait, quhillk is very loathsome to beholders and also raises ane filthie and noysonme stink' – Clarke op.cit. p. 7. This had improved little by the early years of the nineteenth century.

⁶⁵ Alison, op. cit., p.182.

backyards. New tenements were erected round squares which then became built up by the erection of further smaller squares to form a complicated arrangement referred to by Glasgow's Medical Officer of Health as 'Chinese puzzles.'⁶⁶ The dwellings were without drainage or ventilation. The central courts of the 'Chinese puzzles' became middens with dunghills reaching the height of the first floor.

The slum ghettos were persisting nests of typhus and their populations were victims of recurring epidemics of cholera. These were the conditions found by the Poor Law Commissioners visiting Scotland for the Sanitary Inquiry (Scotland) in 1842. Some of the most damning evidence of the appalling housing conditions in the Scotland's cities was provided by doctors – Neil Beaton, Neil Arnott, Alexander Miller, W. P. Alison and Robert Cowan. These doctors could bear witness to the association between the housing conditions and the incidence of fevers and pestilential disease; the overcrowding and squalor the Commissioners could see for themselves.⁶⁷

From the 1840s there was a second phase of industrialisation and the process of urbanisation accelerated, eventually shaping the Scotland of the 1930s. Textile manufacturing was surpassed by heavy industry. Glasgow and the western Lowlands became the Workshop of the World, and supported by a flourishing coal mining industry had coming to dominate the production of ships, locomotives, heavy engineering and steel. Existing industrial cities and burghs expanded and new centres were created, often on greenfield sites and named after the nearest village. In 1831 Coatbridge had been a village of 107 houses on the Monkland Canal;⁶⁸ by 1931 it was a town with a population of over 40,000. Airdrie grew almost as rapidly and acquired 'the ramshackle and dangerous character of a frontier town.'⁶⁹ Although cotton spinning was in decline, the more specialised textile industries prospered – jute in

⁶⁶ E. Robertson, *Glasgow's Doctor: James Burn Russell* (East Linton, 1998), p. 98.

⁶⁷ *Report on the Sanitary Condition of the Labouring Population of Scotland* (Edinburgh, 1842).

⁶⁸ A. Fullerton (ed.) *Gazetteer of Scotland* (Glasgow, 1842).

⁶⁹ T.C. Smout, *A Century of the Scottish People* (London, 1986), p. 9.

Dundee, lace in the Irvine valley, canvas in Arbroath, and high quality woollen goods in the Borders. Hawick soon became as overcrowded as Glasgow.

These upheavals created a new and multiplying urban poor who suffered as much in their diet as in their housing and working conditions. Traditionally the diet of the rural population was oats, barley, peas, potatoes and milk with meat only as an occasional luxury. The basic diet of the new urban poor differed little from that of the rural population but the same food was more expensive and less likely to be fresh. The family diet depended on income and families could only be fed and housed while the breadwinner remained healthy and in employment.

By the middle of the nineteenth century almost nothing had been done to relieve the living conditions of the urban poor. W. P. Alison in his lectures to medical students in Edinburgh and in his *Observations on the Management of the Poor in Scotland* commented on the 'very general discouragement'⁷⁰ of movements to improve the condition of the urban poor. Tucked away in the most squalid parts of the towns and cities the poor, and the squalor in which they lived, were out of sight and more prosperous citizens could remain oblivious to the conditions in the ghettos.⁷¹ There was little public pressure for improvement and central government did not actively intervene in the interest of public health in Scotland until the Public Health Act of 1867. Even then the Board of Supervision⁷² chose not to put pressure on the many local authorities that were reluctant to invest in public health measures. In 1869 the Board issued an 'Instructional Letter' to its officers: 'You will understand that the Board do (*sic*) not expect that the whole of the provisions of the Public Health Act can be immediately and simultaneously put in force in all places.'⁷³

In the second half of the century Britain, as a whole, had begun to enjoy a period of increasing prosperity. In 1851 the *Manchester Guardian* could claim that

⁷⁰ Ibid., p. 21.

⁷¹ Robertson, op. cit., p. 128.

⁷² J.B. Russell, the MOH of Glasgow, referred to the Board of Supervisors as 'an absurd executive'. Robertson, op. cit., p. 91.

⁷³ T. Ferguson, *Scottish Social Welfare* (Edinburgh, 1958), p. 11.

‘we have at least as much, if not more, substantial reason for contentment and thankfulness, than at the close of any past year in our history.’⁷⁴ Food was cheap and plentiful and ‘clothing, fuel, shelter and transition from place to place within the reach of all, except those whom demerit, or extraordinary misfortune, has reduced to complete destitution.’⁷⁵ Working people were beginning to enjoy the benefits as well as the squalor of the Industrial Revolution. Expanding industry provided employment and higher wages. The cotton industry produced cheap washable clothing and the chemical industry cheap soap; personal cleanliness was at least as important as a health benefit from the new water supplies as the safer drinking water. The new railways were more efficient in distributing the food produced by more modern farming to the towns. Protection of home markets had been abandoned and improved transport within North America and across the Atlantic allowed the importation of cheap grain and lowered food prices. Those who suffered ‘extraordinary misfortune’ and even some of those destitute because of ‘demerit’ received support from an extraordinary expansion of philanthropic societies and the widening scope of middle class good works. The process of urbanisation continued but the increasing prosperity and the gradual, even if uneven and haphazard, implementation of public health legislation, prevented any further deterioration in the health and physical well being of the people, certainly in England and Wales.

In Scotland conditions were much less satisfactory. Industrialisation, beginning later, had proceeded even faster than in England. Except in coalmining, even skilled employees in Scotland’s industries earned substantially less than their opposite numbers in England.⁷⁶ The proportion of skilled workers was smaller than in England and wage differentials between the skilled and unskilled and between male and female workers were greater.⁷⁷ Scotland had a low wage economy and greater poverty and

⁷⁴ Quoted by A. Briggs, *Victorian People: A Reassessment of Persons and Themes*, (Folio Society edition, London, 1996), p. 41.

⁷⁵ Ibid.

⁷⁶ W. W. Knox, *Industrial Nation: Work Culture and Society in Scotland, 1800 – Present* (Edinburgh, 1999), p. 90.

⁷⁷ Ibid., p. 91.

support for the poor was slow in coming. The Poor Law (Scotland) Act of 1845 had transferred the responsibility for the poor of each parish from the Kirk Session to new parochial councils under the guidance of a Board of Supervision in Edinburgh. Each parish was directed to appoint an Inspector of the Poor to judge the merits of applications for relief. But there was still no provision for the able-bodied. Only the disabled were entitled to support and the attention of a medical officer. The parochial councils were authorised to levy a compulsory rate for public health measures but it was several years before most parishes in Scotland took up this option. As a result parochial councils, in the great majority of cases, did not have the funds to make full use of their powers. Into the twentieth century spending on the poor in Scotland was considerably more niggardly than in England.⁷⁸

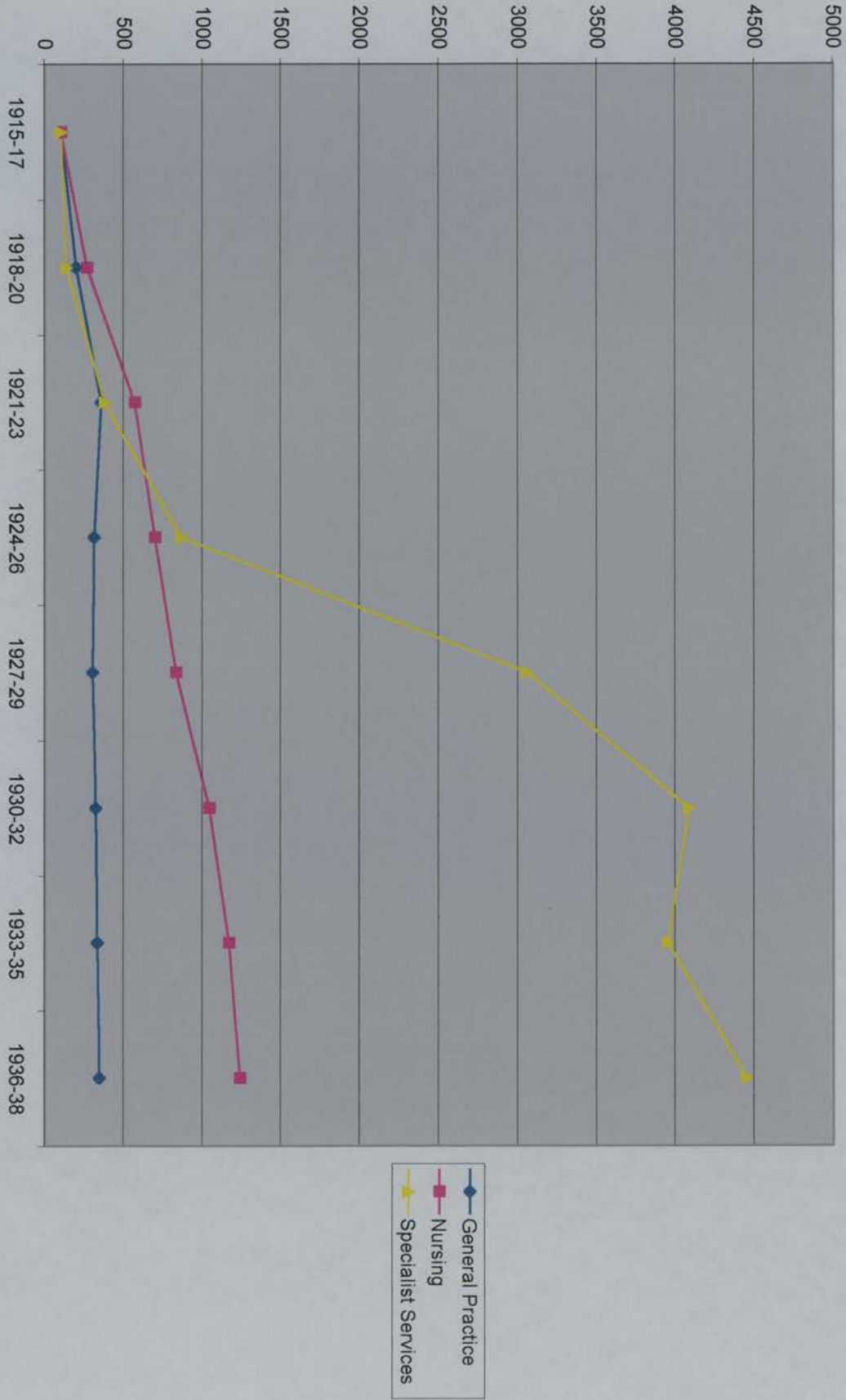
Without active central direction, it was left to local authorities to find their own solutions to their public health problems in local Police Acts. Local authorities varied in their enthusiasm for public health measures and in their financial resources to implement them. In Glasgow a succession of outstanding Medical Officers of Health, supported by sympathetic Health Committees, succeeded in setting up a Public Health service that was ahead of its time in Britain. But overall Public Health services remained patchy and uneven across Scotland until central government, in the Public Health Act of 1897, began to make important public health legislation compulsory.

In these circumstances of poverty and overcrowding the uneven public health measures of the second half of the century were unable to prevent further deterioration in health standards as urbanisation continued. Appendix II shows that the death rates in Scotland which, in the middle years of the century, had compared favourably with those in England and Wales, began to deteriorate as the century advanced and by the end of the century the deaths rates had deteriorated to match those south of the border.

⁷⁸ M. A. Crowther, 'Poverty, Health and Welfare,' in Fraser and Morris, *op. cit.*, p. 269.

HIMS - Percentage Increase in Expenditure

Figure 6



Sources: Annual Reports of the Highlands and Islands Medical Service Board,
Annual Reports of the Scottish Board of Health,
Annual Reports of the Department of Health for Scotland

Over the same period real wages improved by some 45%⁷⁹ and opportunities for regular employment in the industrial regions of Strathclyde and Lothian had more than doubled. Even so, the diet of the working classes as shown by the survey by Paton and his colleagues in 1901,⁸⁰ was still barely adequate.

Improvement in the social conditions began to accelerate in the first years of the new century. In commenting on social conditions in 1936, Cathcart was careful to draw attention to the speed of the 'progress of the last forty years'⁸¹ and to comment on the 'short distance in time that separates us from conditions that would not now be tolerated.'⁸² Cathcart claimed that by the mid 1930s 'with the exception of a few backward areas, practically all populous centres have now more or less adequate services for water, drainage, sewerage, public cleansing and the other elements of sanitation, and, although much progress has still to be made, the housing conditions are greatly improved.'⁸³ Cathcart also claimed that there had been satisfactory progress in the relief of poverty.⁸⁴

Cathcart's optimistic assessment of the improvement in the condition of 'the people' that had been achieved over a century was not substantiated by the only available statistics. The *Annual Reports of the Registrar General for Scotland* and the *Annual Reports of the Registrar General for England and Wales* show that almost to the end of the nineteenth century the problems had hardly been contained at all. Real measurable improvement had begun only in the last few years of the nineteenth century and had then proceeded at a significantly slower rate in Scotland than in England and Wales. While the Infant Mortality Rate and the death rate among those who survived infancy did improve in Scotland over the forty years from 1893 to 1933, the improvement was faster in England and Wales.

⁷⁹ Royale, op.cit. p. 168.

⁸⁰ N. Paton, J. Dunlop and E.A. Inglis, *A Study of the Diet of the Labouring Classes in Edinburgh* (Edinburgh, 1901).

⁸¹ Cathcart Report, p. 41.

⁸² Ibid.

⁸³ Ibid.

⁸⁴ Ibid.

Scotland's poor showing was due to the greater disruption caused to a greater proportion of the Scottish population by the upheaval of the Industrial Revolution than had been the case in England and Wales. In the 1930s the majority of Scotland's population was still suffering from its aftermath. In England and Wales the evil legacy of the Industrial Revolution was confined to certain definable areas of the north and of Wales. In Scotland damaging living conditions were widespread and worse even than in the most distressed areas of England and Wales. Using the general death rate as an index, Table 1 lists the large towns and small burghs which, in the four years up to and including 1933, suffered the worst of Scotland's living conditions. All had death rates more than 50% greater than the prevailing rate for the United Kingdom.

Table 1.

Scotland's Worst Mortality Rates 1930-1933			
Large Towns		Small Burghs	
Glasgow	16.3	Johnstone	17.7
Coatbridge	16.1	Denny	16.9
Paisley	16.1	Lanark	16.2
Greenock	16.1	Hawick	15.5
Port Glasgow	15.9	Alloa	15.5
Falkirk	15.3	Lochgelly	15.3
Dumbarton	15.3	Kilwinning	15.3
United Kingdom	10		

Source: *Annual Reports of the Registrar General for Scotland 1930-33*
Annual Report of the Registrar General for England and Wales 1930

As these figures illustrate, the poor social conditions left in the wake of industrialisation were not confined to the large towns and cities but extended into

almost every part of the Lowlands and Borders and were suffered by a majority of the population. The towns and burghs selected as particular black spots for inclusion in Table 1 were home to no less than 30% of the population of Scotland and conditions in these, the most endangered communities, were not far removed from the average conditions suffered by Scotland's working population. In Scotland as a whole the death rate was over 30% greater than that of the United Kingdom.

In these, the most distressed towns and burghs in Scotland, the population had increased since 1800 (Table 2). In the first phase of Industrial Revolution, Glasgow, Paisley, Johnstone and Hawick and other textile towns increased well above the average rate in Scotland as did the mining villages like Lochgelly. Steel towns like Coatbridge increased dramatically only in the second stage after 1831. It is significant that the increase in these towns and small burghs over the whole period from 1800 varied widely from over 5000% in some to no more than 97% in others and not all had increased beyond the average for Scotland. It is also significant that for over a century the increase in population had been much greater in England and Wales (187.5%) than in Scotland (100.3%)⁸⁵ yet, as measured by death rates, social conditions in England and Wales had never been so badly affected. It becomes evident that increase in population does not, of itself, account for the relatively poor living conditions in Scotland.

A more constant factor was the poor quality of the housing stock. Table 3 shows that in almost all these distressed communities the proportion of the local housing stock made up of houses of one or two rooms was higher than the average for Scotland and in all considerably higher than the average in England and Wales (much higher even than in Northumberland and Durham where in England, the proportion was highest).

⁸⁵ Calculated from N.L. Tranter, *British Population in the Twentieth Century* ((London, 1996) p. 3.

Table 2

Population Increases 1801 - 1931

	Population			Percentage Increase		
	1801	1831	1931	1801-1831	1831- 1931	1801-1931
Large Towns						
Glasgow	83769	202426	-----	141	-----	-----
Glasgow**	-----	280676	1088417	-----	288	1199
Coatbridge	*585	741	43056	*21	5711	7260
Paisley	31179	57466	86441	84	50	177
Greenock	17458	27571	78948	57	186	352
Pt. Glasgow	3865	5192	19580	34	277	406
Falkirk	8838	12743	36565	44	187	314
Dumbarton	*2862	3623	21545	*21	495	653
Small Burghs						
Johnstone	1434	5617	12837	292	129	795
Denny	2033	4027	9488	98	136	367
Lanark	4692	7672	9133	64	19	135
Hawick	2798	4970	18244	78	267	552
Alloa	5214	6377	13322	21	109	296
Lochgelly	*620	785	9297	*21	1084	1400
Kilwinning	2700	3772	5325	40	41	97
Scotland	1625#	2374#	4853#	46	104	199
Eng. & Wales	9061#	13994#	31988#	54	128	253

Sources: *Census of Scotland*, 1931
Gazetteer of Scotland, 1842.
Abstract of Historical Statistics,
B.R. Mitchell Cambridge 1962, p. 9.

* Estimated

** Including burghs previously separate

Thousands

Table 3.

High Mortality and Percentage of Small Houses, Scottish Burghs, 1931

Rooms	1	2	1 & 2		1	2	1 & 2
Large Towns				Small Burghs			
Glasgow	14.5	43.6	58.1	Johnstone	13.2	46	59.2
Coatbridge	23	50.9	73.9	Denny	4.1	40.7	41.5
Paisley	14.9	50.3	65.2	Lanark	8.8	32.7	41.5
Greenock	10.2	44.8	55	Hawick	9	36.2	45.2
Port Glasgow	8	59.5	67.5	Alloa	8.4	32.9	41.3
Falkirk	7.2	46	53.2	Lochgelly	5.2	55.2	60.4
Dumbarton	5.4	42.7	48.1	Kilwinning	15.2	35.4	50.6
Scotland	9.5	36.9	46.4	Eng. & Wales	0.4	4	4.4
				N & Durham	0.7	3.4	4.1

Sources: *Census of Scotland, 1931**Census of England and Wales, 1931*

The small houses in these distressed communities accommodated a proportion of dependant children higher than the average for Scotland and much higher than the proportion in England and Wales. (Table 4)

These differences were a reflection of the changing birth rates. During the nineteenth century, until 1895, the birth rate had been lower in Scotland than in England and Wales. Thereafter the rate fell in both countries. By 1900, while the rate in Scotland had fallen to only 29.6, the rate in England and Wales had reached 28.7. Thereafter the gap between the countries widened progressively. In 1930 the rate in Scotland was 19.6 and 16.3 in England and Wales. The greater numbers of children combined with the smallness of the houses to cause greater overcrowding in Scotland than in England and Wales. The effect of overcrowding is indicated by its particular severity in those Scottish communities that suffered Scotland's highest death rates

Table 4

High Mortality, Percentage of Population 14yrs or Less, Persons/Room (P/R)

Large Towns	%Population 14 yrs. or less	P/R	Small Burghs	%Population 14 yrs. or less	P/R
Glasgow	27.3	1.54	Johnstone	30	1.67
Coatbridge	32.4	2.03	Denny	28.9	1.55
Paisley	46.9	1.62	Lanark	25	1.16
Greenock	30.6	1.61	Hawick	21.1	1.21
Port Glasgow	33	1.93	Alloa	27.7	1.29
Falkirk	26.8	1.49	Lochgelly	32.5	1.77
Dumbarton	29.5	1.48	Kilwinning	30	1.53
Scotland	26.9	1.27	Eng. & Wales	23.8	0.83

Sources: *Census of Scotland, 1931**Census of England and Wales, 1931*

Inadequate housing, large numbers of dependant children and overcrowding were all factors in making living in Scotland's black spots dangerous but none of these variable factors operated consistently in every one of these communities. In each community their effects were cumulative and all were fundamentally expressions of poverty. Scotland's bad housing was essentially attributable to poverty.⁸⁶ The continuing high birth rate and the resulting large numbers of dependant children were also functions of poverty.⁸⁷ There were no relevant official surveys of nutrition in Scotland in the early twentieth century but there were a number of studies from that by Paton and his colleagues in 1901 (above) to that by John Boyd Orr in 1935⁸⁸ that demonstrated that the diet of the masses in Scotland was unsatisfactory and that this too was related to poverty.

⁸⁶ T. M. Devine, *The Scottish Nation*, op. cit., p. 341.

⁸⁷ J. Caldwell, 'Paths to Lower Fertility,' *BMJ*, cccix, 1999, p. 985.

⁸⁸ J. Boyd Orr, *Food Health and Income* (London, 1936).

Scotland, like England and Wales, had suffered during the urbanisation that had accompanied the Industrial Revolution but the suffering had been more general and widespread. Scotland's rate of recovery had also been slower than in England and Wales. Clearly this was not directly related to the size of the increase in population or to the degree of urbanisation both of which had been greater south of the border. The determining factor was poverty, operating through bad housing, continuing large numbers of dependant children, overcrowding and poor nutrition. This relative poverty was long-standing. The poverty caused by the unemployment during the Depression of the 1930s, most severe in the shipbuilding areas of the Clyde (Clydebank, Port Glasgow and Dumbarton⁸⁹) but experienced across Scotland, was no more than an exacerbation of an existing problem.

The extent of Scotland's problems was already a matter of public record in the 1930s. While Cathcart was able to claim that there had been an advance from squalor it also had to be conceded that there was still 'room for improvement'.⁹⁰ Poverty, unemployment, poor housing, overcrowding and poor nutrition still persisted into the twentieth century. These were essentially still the problems identified by Alison in 1840. Alison had shown that while the same problems existed in England they were incomparably greater in Scotland. In Scotland in 1840 wages were lower,⁹¹ unemployment greater, destitution worse, food prices higher and housing more expensive and concern with personal hygiene less than in England.⁹² It was an essential part of Alison's thesis that Scotland and England were different societies and it was not to be expected that they would necessarily progress in tandem or respond to the same measures for improvement. On the available evidence Cathcart could have made the same case in 1936. For centuries Scotland had been a relatively poor country. The years of its Economic Miracle had been too insecurely based⁹³ and too

⁸⁹ *Annual Report of the Department of Health for Scotland*, 1932, Cmd. 4338, p. 182.

⁹⁰ Cathcart Report, p. 45.

⁹¹ Alison, op. cit., p. 74.

⁹² Ibid.

⁹³ R. H. Campbell, *The Rise and Fall of Scottish Industry, 1707- 1939* (Edinburgh, 1980).

short lived to correct that relative poverty. The upheaval of the Industrial Revolution had affected a greater proportion of the population of Scotland and its effects had been more severe even than in the worst affected industrial communities in the south. In the 1930s Scotland, unlike England, had become a proletarian nation.⁹⁴ The culture of poverty was well established in that proletarian population between the wars. Its significance was not recognised in the Cathcart Report but to those of us who saw it in the 1930s and again at first hand during the first years of the working of the National Health Service it was an every day experience. The mass of the people of Scotland were all too ready to look to the state for the management of health problems and had all too many health problems to be managed. And management of their problems was made more difficult by their poverty, poor diet and bad environment. This affected the attitudes of the public towards the NHS in 1948. The expectations were greater in Scotland than in England and Wales but so also were the difficulties for the NHS in meeting these expectations in the condition in which so many of the people lived. This was one aspect of the difference between the NHS in Scotland and the NHS in England and Wales

Health

In the 1930s little was known about the extent of life-threatening disease in the population of Britain and nothing whatever about the amount of minor illness and disability that disturbed the day to day activities of the people. The Cathcart Committee could only attempt a 'general view of the extent and nature of the ill-health'⁹⁵ in Scotland.

For centuries some parishes had kept their own records of deaths and this became a general practice during the nineteenth century. These local registers were not always complete or accurate. Because of long-standing objection by the Church, a

⁹⁴ J. Foster, 'A Proletarian Nation? Occupation and Class since 1914,' in A. Dickson and J.H. Treble, *People and Society in Scotland* iii (Edinburgh, 1992), p. 201.

⁹⁵ Cathcart Report, p. 45.

national registration system was not introduced in Scotland until 1855. However, unlike the system already operating in England and Wales at that time, registration was compulsory in Scotland and the records of the numbers of deaths during the later part of the century may be taken as accurate. Earlier reliable records come only from Glasgow which had maintained an efficient system for the registration of deaths and annual life tables for the city from 1821.

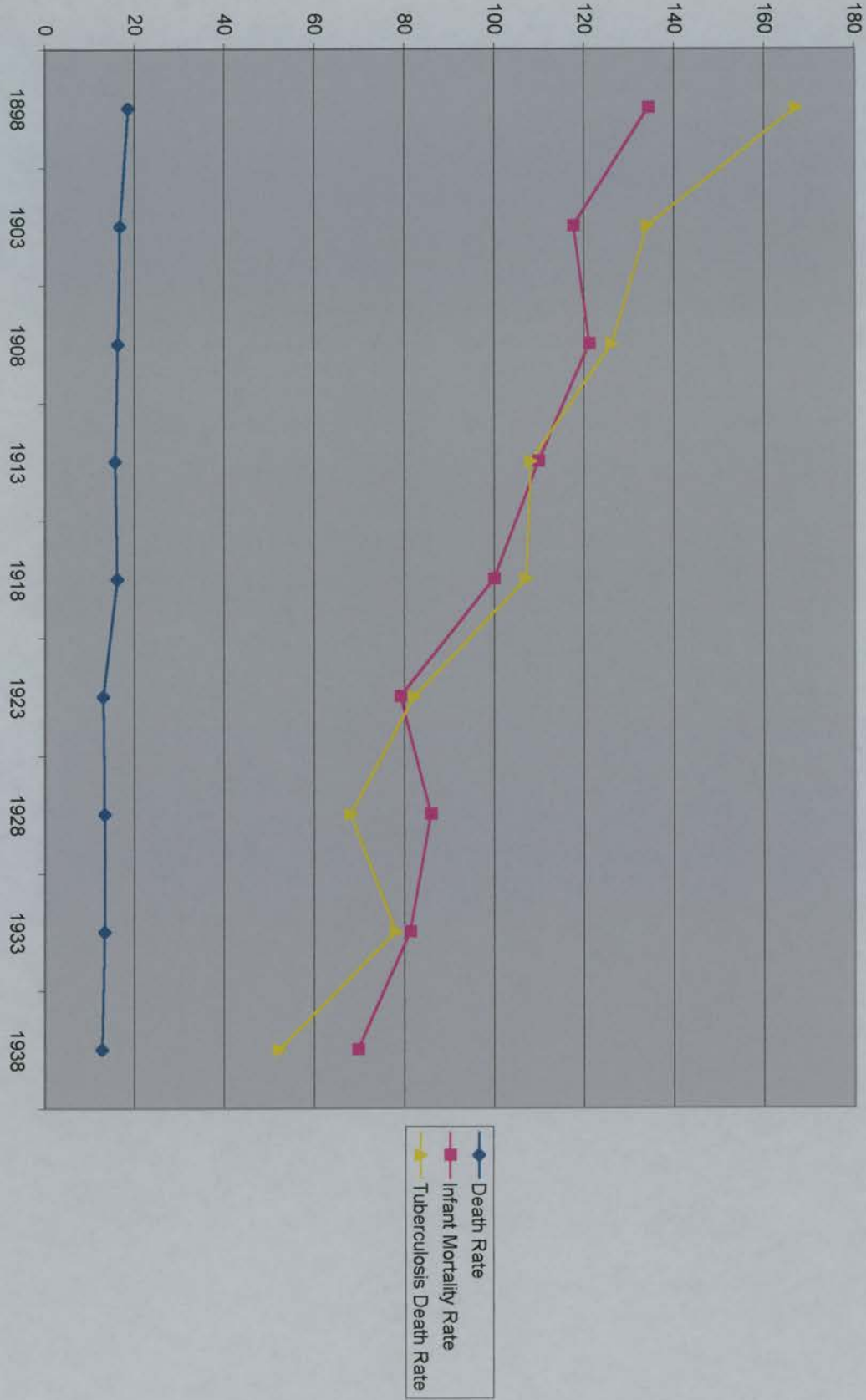
Cathcart made use of the records of death rates only from 1870 when they had already begun to fall, and particularly rates after 1911 when methods of recording statistics was altered. (Figure 1.) In the second half of the nineteenth century public interest was in the total strength of the nation in terms of the number in the population. General death rates gave no indication of the causes of death nor did they accurately reflect longevity; until 1929⁹⁶ that could only be illustrated by Glasgow's life tables. Infant mortality rates only became reliable after registration of births became compulsory in the early twentieth century and did not reveal the cause of death. Only the records of deaths from tuberculosis give information about mortality from a known cause. The Cathcart Committee recruited Dr McKenrick and Dr Kermack of the Royal College of Physicians of Edinburgh and Dr McKinley of the Department of Health for Scotland to make what statistical analysis was possible of the limited information available.⁹⁷

Over the period reviewed, the general death rate had fallen steadily from 22.3 per thousand in 1870-72 to 13.4 in 1930-32. Over the same period the death rates in the major cities had shown greater improvement than the rate for the country as a whole (Edinburgh from 25.9 to 13.4; Glasgow from 30.4 to 14.3; Dundee from 27.5 to 14.3; Aberdeen from 22.8 to 13.4). These figures were accepted as adequate evidence that health in Scotland had improved significantly over this period and that while health in the cities had been worse than in the rest of the country in 1870 the gap had narrowed by 1930. No attempt was made to extract more than these very

⁹⁶ The Department of Health for Scotland produced life tables from 1929.

⁹⁷ Appendix II and III.

Death Rates - Scotland 1898-1938



Source: Annual Reports of the Registrar General General for Scotland

Figure 1

general conclusions from the overall trend of the crude death rate. Changes had been made in the method of collecting the data during the period of observation and the age and sex structure of the population in 1930 was quite different from that in 1870. Even when suitable corrections were made to the figures to make allowance for these variables, a decline in the overall death rate did not of itself reveal much that was useful; it did not show which sections of the population were surviving in greater numbers and therefore gave no indication of which causes of death were being contained or diminished.

For the Report a method of presentation of the death statistics was devised⁹⁸ which made it possible to draw a few but important conclusions. Figures were derived for ten separate age groups, giving the percentage reduction in death rates in each group between 1870-72 and 1930-32. (Table 5). This showed that while every age group had experienced a fall in death rate, infant mortality had fallen less than the death rate at any age group under 45 years of age. This disproved a theory that was prevalent at the time⁹⁹ that efforts to reduce infant mortality were counter productive since they had the undesirable effect of prolonging the survival of weaklings. The statistics produced for the Report showed that this could not be the case. It was also noted that the greatest saving in life was among children between the ages of one and five years, the age group most vulnerable to infectious disease (Figure 2). Based on these and all the other figures the Report ventured the hypothesis that 'the death rates of the adolescent and the adult depend on the constitution acquired during the first fifteen years or so of life and that the latter had undergone a very substantial improvement, presumably as a result of the general rising of the standard of life and the amelioration of social conditions.'¹⁰⁰

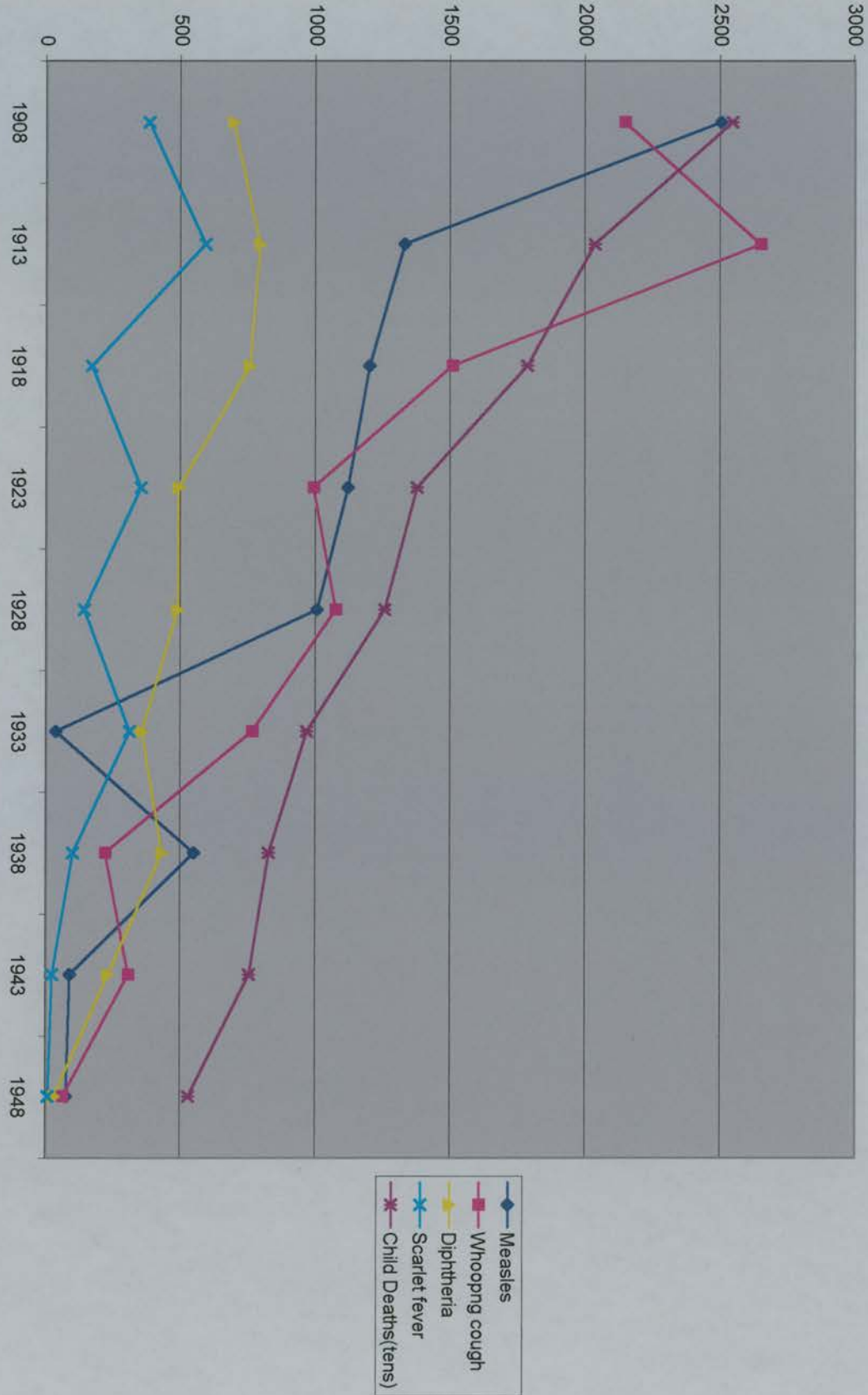
⁹⁸ The statistics were prepared by Dr McKinlay of the Department of Health for Scotland and Drs McKendrick and Kermack of the Research Laboratory of the Royal College of Physicians of Edinburgh.

⁹⁹ Professor Cathcart had himself expressed this fear in his address at Anderson College in 1933. *Glasgow Medical Journal*, i, 1933, p. 185.

¹⁰⁰ *Ibid.*, p. 48.

Infectious Disease and Total Childhood Deaths
Scotland 1908 - 1948

Figure 2



Source: Annual Reports of the Registrar General for Scotland.

Table 5

Expectation of Life at Different Ages-1870/1930

Age	0	5	15	25	35	45	55	65	75
Glasgow									
<i>Men</i>									
1870	30.9	42.9	36.6	30.2	23.7	18	13.1	8.8	5.3
1930	51.3	56.6	48.1	39.6	31.2	23.4	16.2	10	5.7
<i>Women</i>									
1870	32.6	44	38.3	32.4	26.3	20.6	15.1	10.4	6.1
1930	55.2	59.2	50.6	42.2	33.9	25.8	18.1	11.6	6.5
Scotland									
<i>Men</i>									
1870	40.3	48.9	42.3	35.7	29.1	22.7	16.4	10.7	6.3
1930	56.0	59.2	50.4	42.7	33.2	25.1	17.5	11	6.3
<i>Women</i>									
1870	43.8	50.9	44.5	37.7	31.1	24.5	17.8	11.6	6.7
1930	59.5	61.5	52.7	44	35.6	27.3	19.4	12.6	7.1

Source: Cathcart Report p. 378.

These Tables showed very clearly that since 1870 many more people, especially women, were surviving into old age. That the improvement in survival had been greater in Glasgow than in Scotland generally was taken as evidence that over 70 years the threats to life created in the Scotland's industrial centres were being rapidly overcome while recovery was less rapid where the pressures of urbanisation had been less.

The Causes of Death

The Cathcart Committee's statisticians looked for evidence of a changing pattern of disease and this could only be done by examining the causes of death as recorded on death certificates. Records of the causes of deaths were much less certain than records of the numbers of deaths. In the nineteenth century, including the decades after the registration of births became theoretically compulsory in 1855, many deaths went uncertified because no doctor had been consulted about the terminal illness. In Glasgow in 1874 over a third of children dying in the first years of life had not been seen by a doctor; for those between 1 and 5 years the proportion was over a quarter and of those over that age almost 15%.¹⁰¹ In some Highland parishes no cause was established in 75% of all deaths.¹⁰² Not until the first years of the twentieth century did this cease to be a problem.¹⁰³

Analysis was frustrated by other difficulties. In many cases where the death had been certified the diagnosis was grossly inaccurate. For much of the nineteenth century and into the twentieth, it was often impossible to make a reliable diagnosis in the dark overcrowded homes of the poor and, in many cases, the difficulty was made worse by personal filth. 'The skin is to such people virtually a lost organ, coated with the accumulated excretion of years.'¹⁰⁴ Infectious diseases such as typhus were impossible to diagnose until the body had been thoroughly bathed to expose the skin rash. The medical examination of the body before certification was often cursory in the extreme and the diagnosis of acute deaths little more than guesswork.

Even when a diagnosis was made, the classification of disease used in the registration of death was imprecise and unhelpful. A death classified as due to heart disease could have been due to the recent onset of degenerative disease or equally

¹⁰¹ J. B. Russell, *Report on Uncertified Deaths in Glasgow* (Glasgow, 1876).

¹⁰² Ferguson, op. cit., p. 32.

¹⁰³ In 1901 the percentage of death in Scotland going uncertified had fallen to 1.7.

Ibid.

¹⁰⁴ J. B. Russell, MOH of Glasgow quoted by Robertson, op.cit., p. 52.

could have been the late effect of rheumatism or syphilis contracted early in life. Other broad diagnoses – ‘nervous disorders’ or ‘kidney disease’- were equally uninformative. The changing age and sex structure of the population added to the difficulties in detecting a pattern of change over the years.

The statisticians attempted an analysis of the causes of death only for the short period from 1891 and then only in relation to a ‘relatively small number of causes of death.’¹⁰⁵ According to the record of crude death rates, the death rate from cerebral haemorrhage in 1930-32 had increased by 42% since 1910-12; when the figure were corrected for age it could be shown that the incidence had actually declined. Similarly it could be shown that an apparent increase 42% in deaths from cancer was in fact only 9%.

The Report concluded that, from the records of the causes of death, as they existed in 1936, ‘detailed comparisons with past experience are not possible.’

Sickness and Defect

Until the end of the nineteenth century the records of the incidence of disease (as opposed to deaths from disease) were unreliable. Provision for the notification of infectious disease was made first in Glasgow and later incorporated in various Police Act for Edinburgh, Dundee, Aberdeen, Kilmarnock, Hamilton Coatbridge and Greenock in the course of the nineteenth century. The Infectious Disease (Notification) Act, applying to the whole of Scotland was not passed until 1889 and was then only adoptive and applied only to smallpox, cholera, diphtheria, erysipelas, scarlet fever and the ‘fevers known by any of the following names- typhus, typhoid enteric, relapsing, continued or puerperal.’¹⁰⁶ Notification of infectious disease (now including all forms of tuberculosis) became compulsory in 1897 but even then it was far from being an exact science. During the period from 1891 reviewed for the Cathcart, the statistics were sufficiently accurate only to indicate some general trends.

¹⁰⁵ Cathcart Report, p. 50.

¹⁰⁶ Quoted from the Act by Ferguson, op.cit, p. 405.

By 1891 smallpox and typhus had disappeared completely. Over the period of the review there were marked reductions in deaths from all the commoner infectious diseases – abdominal tuberculosis by 71%, pulmonary tuberculosis by 65%, scarlet fever by 63%, diphtheria by 66%, measles by 68% and whooping cough by 59%, erysipelas by 39%. There had also been significant reductions in ‘dysentery and diarrhoea’ (listed together without mention of typhoid) and in ‘infectious and other parasitic diseases.’

The Cathcart Committee was unable to draw any conclusion about the cause or causes of these trends and reported only the theories put forward by medical witnesses. The marked decline in deaths from enteric fevers and the diarrhoeal illnesses of children was attributed to the introduction of pure water supplies, the diminution of the fly menace and the increase in communal and domestic cleanliness; the fall in mortality from scarlet fever was attributed to a (speculative) lessening in the virulence of the infecting organism; the lessened death rate from diphtheria could possibly be attributed in small part to the very recent introduction of serum treatment;¹⁰⁷ the incidence and severity of measles and whooping cough had perhaps declined as the result of improvement in nutrition and overcrowding. However, none of these explanations was entirely convincing; nor was the suggestion that the decrease in the severity of the infectious diseases of children might be associated with the decline in the incidence of rickets in Scotland’s cities. Cathcart concluded that any ‘deductions relating to the future incidence and severity of infectious disease should be made with caution.’¹⁰⁸

There was almost no hard information about disease, other than notifiable infectious disease, in the general population. The ill-defined disorder of rheumatism had declined by 40% and bronchitis and pneumonia by 44%. It was tentatively suggested that these improvements might be the late effects of the diminution of

¹⁰⁷ Serum treatment had been possible since 1891 but its use met with resistance and introduction into practice had been slow.

¹⁰⁸ Cathcart Report, p. 56.

infectious disease earlier in life. Other disorders had been increasingly recorded as the cause of death - cancer by 56%, Bright's disease (nephritis) by 46%, suicide by 41%, diseases of the nervous system by 25%, violence by 16% and diseases of the circulatory system by 5%.¹⁰⁹ These increases might possibly be related to the ageing of the population rather than to a true increase in incidence. However the explanations for the changes in the pattern of disease as reflected (indirectly and unreliably) in the recorded causes of death remained obscure.

The School Medical Service provided little information on what was an important sample of the population. As will be discussed later, school medical inspections provided more information on the physical appearance of the children than on their state of health. Information on the adult population was no better. Since 1930 the Morbidity Statistics Scheme, set up by the Department of Health for Scotland to record incapacitating illness in the insured population, had provided information on a large sample of the adult population. But only disorders causing absence from work were recorded. The scheme therefore did not reveal the incidence of the common chronic disorders – hernias, migraine, haemorrhoids, chronic bronchitis, carbuncles – that made up such a large proportion of the medical problems of the mass of the working population.

From the very little reliable information available Cathcart could only conclude that the amount of sickness in the population was very great and that 'there was ample scope for reduction.'¹¹⁰

Anthropometric Data

There was even less information about the growth and physical development of the people. In 1903 the Royal Commission on Physical Training and, in 1904, the Interdepartmental Committee of Physical Deterioration had deplored the lack of

¹⁰⁹ Further details of deaths and causes of deaths are given in tables in Appendix IV of the Cathcart Report. However as these are crude figures uncorrected for age or sex and the diagnoses are imprecise further analysis is not worthwhile.

¹¹⁰ Cathcart Report, p. 79.

anthropometric data and the Inter-Departmental Committee that followed had recommended that an anthropometric survey should be established. This had not been done and by 1936 the only data available was from Glasgow and derived entirely from children attending school. (Disabled children and children with chronic illnesses were therefore excluded.) Measurements made at the age of five years and again at nine years and at 13 years showed that there had been significant increases in both height and in weight over the period from 1910 to 1933. The increases in boys ranged from 0.7 ins. and 0.9 lb. in five year olds to increases of 1.5 ins. and 5.5 lb. at 13 years; in girls from 0.8 ins. and 0.1 lb. at 5 years to 1.3 ins. and 2.8 lb. at 13 years. It was also shown that these increases were shared by children of all classes.¹¹¹ Sir Leslie Mackenzie of the Scotch Education Department and other experts accepted that the data were sufficient to establish that Scottish children in 1933 were 'better physically' than their predecessors. Cathcart was more cautious; height and weight were measures of growth and by themselves were of little significance as indicators of health or nutrition of individual children. Although measurement of comparable groups of children at different times and under different circumstances had been used by many investigators as indications of improved nutrition Cathcart was unwilling to accept such conclusions in the absence of other supportive evidence.

While the Cathcart Committee considered that no matter what interpretation was put on the improvement in height and weights of a small sample of Scottish children, it certainly could not be taken to signify an improvement in the nutrition or a relative absence of disease in the general population.

Observations and Impressions of Medical and other Witnesses

Without satisfactory hard evidence on which to base a sound assessment of health in Scotland, Cathcart recorded current opinions. A number of medical witnesses attested to a striking decline in rickets, especially in its more severe forms. Medical witnesses

¹¹¹ Indicated by the number of rooms in the family home.

from the larger towns reported that although rickets was still not uncommon it was now in much milder type than formerly. One medical practitioner in the north of Scotland stated that he had not seen a case for many years. This evidence is at least questionable. Twenty years later I still met new cases of rickets in children in Glasgow and the deformities of old rickets were to be seen in the streets as an every day occurrence.

On blindness, the Committee had anecdotal evidence suggesting that ophthalmia of the newborn had become rare and that infections of childhood were less frequently followed by loss of vision. But nothing at all was known of the trend in blindness due to congenital causes, injuries or the affections incidental to old age. The incidence of deaf mutism among Scottish school children was thought to be decreasing since, between 1891 and 1931, there had been a definite decrease in the number of such children attending schools for the deaf and of the children the proportion with acquired deafness had fallen from 50% to 27.8%. Although there was no good evidence of a causal relationship, this was attributed to early diagnosis and treatment by the School Medical Service.

It was suggested by a number of witnesses that venereal diseases had become less common but Cathcart considered the information on the venereal diseases to be too recent to enable a categorical statement to be made.

Pernicious anaemia and diabetes provided more substantial evidence of an improvement, if not in the incidence of disease, at least an improvement in management. The *Annual Report of the Registrar General for Scotland* for 1931 had shown that the mortality from pernicious anaemia had fallen by a half since liver extract was introduced over the period 1921-1926. There had been a similar improvement in the survival of young adults suffering from diabetes following the introduction of insulin treatment.¹¹²

¹¹² Cathcart Report, p. 57.

On mental disorders the evidence submitted to the Cathcart Committee was as uncertain as that relating to physical disease. The Committee found that 'it is not possible to say by reference to any body of statistics whether or not mental disease and psychoneurotic conditions are increasing.' The number of certified lunatics had increased from 205 per 100,000 of the population at 1861 to 392 per 100,000 in 1931. To what extent this represented a true increase was uncertain. One authority stated 'that the number of mental defectives is increasing is very largely due to different diagnosis. Forty years ago almost half the cases that are now being certified as mentally defective would not have been so certified.' There was greater confidence among the expert witnesses that psychoneurotic illnesses had increased. The Industrial Health Research Board reported that 'not less than 10-20% of time loss through sickness by employed persons should be debited to the so-called psychoneuroses or minor psychoses.' There was also a growing body of opinion that the psychological determinants of ill-health had been underestimated and that organic disease was often intensified by accompanying psychoneuroses. A leading authority attributed the apparent increase in psychoneurosis to 'the change in ethical and moral standards that has taken place.'¹¹³ In the absence of hard information Cathcart accepted the opinion of the acknowledged experts of the time that the incidence of mental deficiency had probably remained constant while there had probably been a true increase in psychoneurosis.¹¹⁴

Conclusion

The Cathcart Committee made every effort to determine the extent and the nature of the ill-health suffered by the people of Scotland. It was hoped to provide firm evidence that the health of the people had, in fact, improved over the previous

¹¹³ Ibid., p. 61.

¹¹⁴ 'The stress and anxieties of present-day living have been potent agents in the production of the neuroses, while a widespread pursuit of pleasure and excitement with a corresponding lack of balance among the post war generation is to be regarded with some anxiety.' Memorandum from the Royal College of Physicians of Edinburgh. Cathcart Report, p. 60.

hundred years; it was only able to conclude that the limited evidence available was compatible with that assumption. The Committee was satisfied that it had been clearly established, over the period reviewed, that there had been a significant prolongation of life at all ages; but in the absence of proof it could only be assumed to have been accompanied by greater freedom from sickness, ill-health and physical defects and had not merely extended the duration of disability.

After the most the careful investigation possible in the 1930s, the Cathcart Committee found that 'it would be impossible for us to present anything like a complete picture of the present state of the people.'¹¹⁵ Although the general level of health was no doubt higher than it had been in the previous century there was still 'a large mass of sickness and defects.'¹¹⁶ But since much of the country's disease and disability never came 'within the purview of the local authorities'¹¹⁷ the true extent of the burden of illness could not be known.

Although the volume of illness remained unknown, Cathcart was able to detect important changes in the pattern of disease. There had been a great reduction in the number of deaths from infectious disease but there had been no proportionate decline in the incidence of infectious disease. The incidence remained high especially among children and recovery was often incomplete, increasing the volume of chronic disorders in the adult population. (Cathcart does not seem to have noticed that the introduction of modern treatments such as those for pernicious anaemia and diabetes had exactly that effect. The patients no longer died but continued to need treatment for an indefinite number of years. Many other modern treatments that prevented death but did not 'cure' were introduced after the Report was published, adding to the numbers of the chronic sick to a degree that Cathcart could not have forecast.)

Cathcart noted that, already in the 1930s, the greater rates of survival into middle and old age had caused an important change in the general pattern of disease.

¹¹⁵ Cathcart Report, p. 65.

¹¹⁶ *Ibid.*, p. 84.

¹¹⁷ *Ibid.*

The incidence of the conditions associated with ageing - cancer, chronic bronchitis, and degenerative circulatory and mental conditions - were increasing in the population and the increase could be expected to continue. In the case of cancer, Cathcart believed the increase was greater than could be accounted for simply by the increase in the number of older people. Cathcart assumed that the increase in malignancy was real.

Although it seemed certain that chronic illness and degenerative disease would increase, Cathcart forecast that they would continue to be vastly outnumbered by the minor disorders which did not threaten life or lead to long lasting disability but caused temporary disruption of employment or other normal activities and comfort. The Morbidity Statistics Scheme, initiated in 1930, had already brought to light the great volume of these disorders – ‘common colds, influenza, catarrhal affections of the throat and nose, and tonsillitis, gastritis, the various manifestations of rheumatism, inflammations of skin and septic conditions, and by a vague and ill defined group of affections of the heart and nervous system into which a psychoneurotic element enters or in which mental symptoms predominate.’¹¹⁸ Cathcart suggested that it was these complaints that would make up the chief burden to be taken on by a comprehensive medical service.

The Cathcart Committee’s predictions of the changing pattern of disease were logical and, in time, proved to be correct. Its Report was helpful in foreseeing the general shape of the health problem that would face the NHS in the future. However the best efforts of the Committee failed to provide sufficient warning of the sheer volume of sickness and disability that would suddenly confront the NHS in 1948. As has been shown, this deficiency in the Report was unavoidable. But as the result of a perceived need for circumspection, the Cathcart Committee did not stress the full severity of the social conditions - poverty, overcrowding, poor diet, destructive life style - that lay at the root of Scotland’s dismal health record.

¹¹⁸ Cathcart Report, p. 84.

The assessment of the social conditions and health of the people presented in the Cathcart Report was not entirely satisfactory. When the White Paper on the NHS was drawn up in 1942 it was the best available review¹¹⁹ but it did not provide the depth of intelligence and analysis necessary for the rational planing of a comprehensive health service, even for Scotland. In part this was unavoidable. The necessary information on the incidence of disease and disability was not available. However, the greatest disappointment was that the Cathcart Committee, for reasons of polity, made no assessment of the social conditions that lay behind the diseases and disabilities although the relevant information was available in the record of the Registrar General for Scotland and the Department of Health for Scotland. This was a disappointment for Scotland; since no study comparable to the Cathcart Report was attempted for England and Wales, it was also a disappointment for Britain. A few years later the planners of the NHS were working in the dark.

¹¹⁹ More limited surveys had been carried out in England notably *The Social survey of Merseyside in 1928* and the *New Survey of London Life and Labour* in 1933.

CHAPTER FIVE

THE DETERMINANTS OF HEALTH

In a new policy for health, the Cathcart Committee proposed that the state should no longer be essentially defensive, intervening only to protect the population by public health measures, and providing personal health services only as additional support for certain particularly vulnerable groups. The state was to adopt a more positive approach. Personal medical services would be made comprehensive in scope and available to all. But, while corrective and restorative services would continue to be essential and a responsibility of the state, they would play a secondary role in the state's positive campaign to promote health. The individual citizen was to be encouraged to take responsibility in promoting and maintaining his own health; the state's primary role was to attend to those factors which made a healthy life possible and which could be influenced positively by government action – heredity, nutrition, housing, the environment and education. In the 1930s each of these matters presented its own particular set of difficulties for the Cathcart Committee.

Heredity

In reviewing the health of the people of Scotland the Cathcart Committee had made no mention of heredity. But in considering the part the state might play in promoting the health of the people, in the 1930s it would have been quite impossible to neglect the disputed potential of eugenics. Eugenic programs had been introduced in almost every country in Western Europe and North America except Britain and many in Britain had come to believe that only eugenics could 'save the world'.¹

In 1888, it had been feared that 'the great cities are the graves of our race.'² It seemed then that working class families, in London and the other great cities, could

¹ C. W. Saleeby, *Parenthood and Race Cultures* (London, 1909), p. 182.

² F. Farrar, *The Fortnightly Review*, 4 March 1888.

survive beyond the third generation only with 'a steady influx of sound, energetic, physically strong recruits from the salubrious countryside.'³ By 1903 even that mechanism for survival seemed to be failing. 'The people residing in urban districts already number four fifths of the population and the proportion is rising, while the country bred who in the past recruited the weakened blood of the cities are either stationary or actually decreasing.'⁴ In Parliament, Lord Meath set out the problem as it appeared at that time. The size of the population, then accepted as a sure measure of the strength of the nation, was clearly in decline; the decline was greater among the more prosperous and the better educated; the poor and less successful were reproducing at a greater rate than their betters; the poor, deteriorating in the urban conditions in which they lived, were passing on their acquired defects to their overnumerous offspring, producing a race of deteriorating quality.⁵

In the aftermath of the Boer War the quality of the people had become a cause of acute concern. The disappointing performance of the British forces had given rise to a drive for 'National Efficiency.'⁶ Proclaimed by Lord Rosebery in his Rectorial Address at Glasgow University in 1900, National Efficiency was for a time an attractive and adaptable, even if very uncertain, ideology which grouped together all manner of projects intended to rescue the nation from decline. In most fields of national activity the drive for Efficiency soon died, but the promotion of National Efficiency by improving the quality of the people attracted much more lasting attention. The idea of eugenics had obvious attractions although its acceptability, morally and ethically, was uncertain. Nevertheless, for some influential enthusiasts, eugenics came to transcend politics, ethics or any other system for the improvement of the condition of man.⁷

³ R. Soloway, *Demography and Degeneration* (North Carolina, 1990), p. 39.

⁴ Ibid.

⁵ The Earl of Meath, *Hansard*, cxxiv, HC 6 July 1903, col. 1324.

⁶ P. Addison, 'Churchill and Social Reform,' in R. Blake and W.R. Louis (eds.), *Churchill* (Oxford, 1996), p. 59.

⁷ Saleeby, *op.cit.*, p. viii.

Francis Galton had first introduced the concept of eugenics in his *Inheritance of Human Faculties* in 1883, several years before the emergence of the science of genetics. For centuries farmers and others had improved the quality of their stock artificially, and in a very few generations, by selective breeding. Galton proposed that the race of men could be similarly improved artificially by using two complementary approaches – by getting rid of the ‘undesirables’ and multiplying the ‘desirables’.⁸ However any scheme, like that of the farmers, had to be based on the simple observation that like seems to breed like. Without a fuller understanding of the mechanisms of inheritance Galton’s eugenics was no more than a hopeful idea.

In 1900 eugenics began to find a more secure scientific basis. Following his re-discovery of the Mendel’s studies of the inheritance of characteristics, published in an obscure journal in 1865, Hugo de Vries developed a new Mendelian hypothesis of inheritance. This was taken up at Cambridge as the basis of a new academic discipline of genetics and although understanding of inheritance was still at a primitive stage uncertain and disputed scientific basis, enthusiasm for eugenics increased.

However even the most enthusiastic eugenicists accepted that they could not run too far ahead of public opinion. This was a difficulty that had to be overcome by the ‘education of the democracy’⁹ before legislation for eugenic measures could become a political possibility.¹⁰ ‘About two hundred people of influence’¹¹ came together to form the Eugenics Education Society (EES) to provide that education and to encourage public support. The EES was promoted by the Fabian Society and many of those who were to become influential between the wars – including J. M. Keynes, Harold Laski, J. D. S. Haldane, H. G. Wells, G. B. Shaw – became members. Eugenics

⁸ D.L. Kelves, ‘From Eugenics to genetic Manipulation,’ in J. Krige and D. Pestre *Science in the Twentieth Century* (Amsterdam, 1997), p. 301.

⁹ A. F. Tredgold, ‘Heredity and Environment in Regard to Social Reform’, *Quarterly Review*, ccxix, 1913, p. 382.

¹⁰ Tredgold reflected the uncertainty in 1913. In his view the Mendelians and the Biometricians were still not reconciled and ‘certain forms of germinal deficiency may be caused by adverse environment.’ Tredgold, op. cit., p 381.

¹¹ Searle, op.cit. p. 10.

gained wide support in the universities, especially among biologists and sociologists. (Many politicians were eugenisists but, with Balfour as the only notable exception, they were reluctant to declare their position by joining the EES.) Eugenists looked to the potential of both positive and negative eugenics. Positive eugenics presented the attractive prospect of improving the race by promoting breeding from the best stock. The Fabian Society hoped to correct the differential birth rate by a system of family allowances for the more able sections of society ('Endowment of Motherhood'). More active programs of selective breeding were clearly impossible; apart from the immediate practical and ethical difficulties, there was no clear definition of the desirable human qualities that should be encouraged. The promotion of negative eugenics was more feasible. While some of the same ethical and practical problems would have to be overcome, the undesirable qualities that a program of negative genetics might eliminate were more easily identified. The attentions of the EES and eugenists therefore tended to focus principally on preventing the reproduction of the 'unfit' and particularly the mentally 'unfit'.

The eugenics lobby had its first real success in influencing the Royal Commission into the Care and Control of the Feeble Minded in 1904. This investigation had been set up by government in response to the concern of prison and poor law authorities about the rising cost of maintaining large numbers of the feeble minded in custody. The Commission was persuaded by leading eugenists that feeble-mindedness was a hereditary condition and that the feeble-minded, as a class, had a fertility well above the average. The Commission therefore recommended that the feeble-minded should be segregated, not only from the general community, partly in the interest of the majority and partly for their own protection, but also by sex to prevent their procreation. This proposal was endorsed by both the Majority and the Minority Poor Law Commissioners but no immediate effective government action followed. The matter was taken up briefly in 1910 by the Home Secretary, Winston Churchill, who was concerned

that there were at least 120,000 feeble minded persons at large in our midst who deserve all that could be done for them by a Christian and scientific civilisation now that they were in the world but who should, if possible be segregated under proper conditions that their curse died with them and was not transmitted to future generations.¹²

Churchill drafted a Bill that would have allowed those feeble-minded who had been confined to be offered release on condition that they were first sterilised.¹³ The Bill to that effect lapsed when he left the Home Office in October 1911. The EES and other interested groups continued their pressure and a new Bill was drafted. Some sponsors of the Bill wished to make it an offence to marry a defective; others proposed to sterilise all defectives. The Mental Deficiency Act of 1913,¹⁴ was less radical. No provision was made for sterilisation but four groups were to be compulsorily institutionalised and segregated – idiots, imbeciles, the feeble minded, and moral imbeciles.¹⁵ These groups consisted mainly of defectives who had come to the attention of the authorities because they were already in prisons, lunatic asylums or workhouses, or had been picked up in the street without visible means of support, or as habitual drunkards. Those women in receipt of public relief during the pregnancy or at the time of giving birth to an illegitimate child, were also to be compulsorily institutionalised. This last group was to be particularly targeted since it was believed that the number of such feeble minded young women was on the increase. The government hoped to solve what was thought to be an increasing problem of lax morality and feeble-mindedness among women.¹⁶

The Mental Deficiency Act came into effect in April 1914 but its implementation was inhibited by the First World War and by the early 1920s little had been done to implement the Act of 1913.¹⁷ The necessary institutions had not been

¹² W. S. Churchill quoted by H.G. Simmons, 'Explaining Social Policy: The English Mental Deficiency Act of 1913', *Journal of Social History*, xi, 1978, p. 386.

¹³ This practice had already been widely adopted in the United States.

¹⁴ In Scotland the Mental Deficiency and Lunacy (Scotland) Act, 1913

¹⁵ A classification that was ill-defined at that time and is now unrecognisable

¹⁶ Simmons, *op. cit.*, p. 389.

¹⁷ The membership of the EES had dispersed during the war and its provincial branches had been disbanded.

built; parents had proved reluctant to agree to the certification of their children as mentally abnormal; doctors had been unwilling to certify patients against the wishes of their families.¹⁸ Even more important, social attitudes had changed and there was no longer general support for either the purpose or the provisions of the Act. Scientific opinion had also turned against eugenics 'because of the scientific shoddiness that coloured its theories of human heredity.'¹⁹ Eugenic science was also suspect 'for its racial and class bias'²⁰ and for its disregard for the effects of social and cultural environment.

However Britain's fiscal difficulties began to revive the anxieties of those who had to find the cost of institutionalising the mentally defective and the criminal. In February 1929 the Minister of Health, Neville Chamberlain, received a petition, once again urging the sterilisation of criminals and mental defectives. Chamberlain set up a Joint Committee of the Board of Education and the Board of Control on Mental Deficiency to inquire 'into the possibility and advisability of legalising sterilisation under proper safeguards and in certain cases.'²¹ The Joint Committee took account of experience in other countries. Since the early years of the century sterilisation laws had been passed in more than twenty American States, and in Alberta, Sweden and Switzerland. However public opinion in most countries and States had remained effectively opposed to sterilisation on humanitarian grounds.²² In America the laws had only been enforced on any considerable scale in two States. The results of the program in California, where sterilisation legislation had been in operation since 1909, had been published and a review published in London in 1929.²³ The reports on the Californian program claimed, in the light of their experience, that if mental defectives in the school system were sterilised, the number of mentally defective persons in the community could be reduced by as much as half in three or four

¹⁸ Simmons, op.cit., p. 390.

¹⁹ Kelves, op. cit., p. 310

²⁰ Ibid.

²¹ *BMJ*, i, 1929, p. 481.

²² *Lancet*, ii, 1929, p. 143.

²³ E. S. Gosney and P. Popenoe, *Sterilisation for Human Betterment* (London, 1929).

generations.²⁴ From a smaller series in Switzerland it was reported that after castration a number of patients formerly unable to live in the community were able to go back to a normal social life.²⁵

In the first part of its report²⁶ the Joint Committee concluded that if mental defectives in the current population were sterilised only after they had been certified, this would have little effect in reducing the incidence of mental deficiency in the next generation. The Joint Committee was persuaded that mental disease was a genetic as well as a social problem and that 'if we are to prevent the racial disaster of mental deficiency we must deal not merely with mentally defective persons but with the whole subgroup from which the majority of them come.'²⁷ In the second part of its report the Joint Committee looked at possible social benefits, suggesting that by sterilising some groups of certified mental defectives it would be possible to return them safely to the community, thus reducing the financial burden on the state of their maintenance in institutions.

The *BMJ* was horrified. Dismissing the American trials as biased and unscientific, it went on to state that if 'nothing short of the sterilisation of one-tenth of the whole population can be an effective preventive measure along such lines, the question whether systematic sterilisation should be resorted to has only to be asked to be dismissed.'²⁸ In a leading article the *BMJ* also dismissed as a crank W. G. Gallichan, who, in a book also published in 1929,²⁹ had claimed that 'the alarm now shown by an increasing number of responsible citizens in the United Kingdom lest the unfit may soon vastly outnumber the fit is almost of the nature of a panic.' The book was condemned as misleading and hysterical, 'illustrating the kind of propaganda to

²⁴ Ibid.

²⁵ *BMJ*, ii, 1929, p.1070.

²⁶ *Report of the Joint Committee of the Board of Education and the Board of Control on Mental Deficiency*, HMSO, 1929.

²⁷ *BMJ*, ii, 1929, p. 108.

²⁸ Ibid.

²⁹ W. M. Gallichan, *Sterilisation of the Unfit* (London, 1929).

which the population is being subjected on the subject of sterilisation.’³⁰ The *BMJ* was convinced that ‘all compulsory measures are beyond practical possibility.’³¹ It conceded only that any measure that might result in the safe return to the community of a somewhat larger number of defectives than would otherwise be possible, merited further investigation.

The *Lancet* was even more restrained. It published a summary of the report of the Joint Committee on Mental Deficiency without comment³² but later reviewed an article by K.B. Aikman in the *Edinburgh Review* in which the author attacked the doctrine of the equality of man and deplored the ‘suicide of the middle classes’.³³ Dr Aikman argued that rather than attempting to influence the breeding of those few at the extremes – the frankly mentally defective and the ‘highly superior,’ much more would be gained by using economic inducements to increase the family size of the mass of people just above the mean and to reduce the numbers just below the mean. The *Lancet* claimed that economic measures had been tried before and had always failed. It also doubted that the necessary efficient ‘selection of individual beneficiaries by bureaucrats’ could be expected. The *Lancet* insisted that no measure should be introduced that might interfere with the liberty of the subject and drew attention to useful reforms that could be achieved easily and without reasonable objection. For example, there was no law in Britain requiring that persons discharged from mental hospitals should be warned that their weakness might be transmissible. The *Lancet* particularly deplored the common practice by which magistrates discharged mentally defective girls from asylums only on condition that they married.³⁴

In December 1933 the *BMJ*, still resolutely opposed to compulsory sterilisation, reprinted in full a lecture on ‘Eugenics and the Doctor’³⁵ given by Lord

³⁰ *BMJ*, ii, 1929, p. 1069.

³¹ *Ibid.*

³² *Lancet*, ii, 1929, p. 142.

³³ *Ibid.*, p. 566.

³⁴ *Ibid.*, p. 144.

³⁵ Lord Horder, *Eugenics and the Doctor*. Lecture to the Hampstead Hospital Postgraduate Session and published in December 1933. *BMJ*, ii, 1933, p.1057.

Horder, not only a leading member of the medical profession in London, as has been described, but also a prominent eugenicist.³⁶ Horder accepted that eugenics must 'seek only to operate by voluntary measures, thus doing nothing by which the liberty of the individual may be infringed.'³⁷ However he suggested that local authorities should be empowered to provide instruction on contraceptive methods for married women on economic and eugenic grounds, in addition to the gynaecological and medical grounds which were already allowed. Horder believed that birth control, as then practised, was acting dysgenically; while practised by the educated sections of society, it was not practised by the less well endowed 'from want of adequate knowledge.' Not only did this virtual 'veto put upon the spread of contraceptive methods' enhance differential fertility, it also encouraged the dangerous practice of abortion.

Horder believed that while compulsory sterilisation was legally enforced in some countries, in Britain even voluntary sterilisation, sanctioned by the patient and his responsible relatives, was still an actionable offence. Horder recommended that in the case of mental defectives and mental convalescents voluntary sterilisation should be made legal as an alternative to segregation.³⁸ He accepted that there were difficulties to be overcome before such a scheme could be introduced. First there was the attitude of the public. For the great majority, 'either from sheer exigency, or from fundamental inability to think clearly, there is a dull acceptance of things as they are.' But there was a minority able 'to project the problem outside themselves.' Of these, one section believed that, as this was the best of all possible worlds, any attempt to exercise biological control over heredity was meddlesome interference. Another section he believed to be persuaded principally by their religious beliefs in actively opposing all eugenic measures; this section of the population was encouraged by the church to regard the arrival of each new individual as a direct act of providence. He

³⁶ Lord Horder, physician to King George V and senior physician at St. Bartholomew's Hospital.

³⁷ *BMJ*, ii, 1929, p. 1058.

³⁸ *Ibid.*

quoted the Bishop of Exeter - 'If the Lambeth conference should approve birth control then there will be a new breach in the growing unity of Christendom.'

Lord Horder urged that the public should be persuaded to think of their responsibility to future generations. Voluntary schemes of eugenics were clearly necessary, but would be impossible until the public was convinced of their benefits and their morality. It would also be essential for the medical profession to be better informed³⁹ since the informed general practitioner would be vital, 'for without him this newest and most hopeful of the humane sciences must inevitably stand still.'

As a result of the country's financial problems in the 1930s, there was further pressure from the local authorities. The segregation required by the existing legislation was proving difficult; the number of institutional beds in place was far short of the estimated requirement. In June 1932, following a deputation from the County Councils Association, the Association of Municipal Corporations and the Mental Hospitals Association, the government appointed a Departmental Committee under the chairmanship of Sir Lawrence Brock, the Chairman of the Board of Control:

To examine and report on the information already available regarding the hereditary transmission and other causes of mental disorder and deficiency; to consider the value of sterilisation as a preventive measure having regard to its physical, psychological and social effects and to the legislation in other countries permitting it; and to suggest what further inquiries might usefully be undertaken in this connexion.⁴⁰

By 1932 the science of genetics had moved on. Biologists had come to see that biometrics and the Mendelian genetics were entirely compatible. The differences that had caused acrimonious disputes at the beginning of the century were finally resolved by the publication of *The Genetic Theory of Natural Selection* by R. A. Fisher in 1930. By then even the initially sceptical T.H. Morgan and his group at Columbia University in New York, had not only accepted the Mendelian model and the

³⁹ Genetics was not taught formally at any British medical school at that time. (Horder, 'Eugenics and the Doctor,' op.cit., p. 1059; *Medical Directory*.)

⁴⁰ *Report of the Departmental Committee on Sterilisation*, Cmd. 4485, 1933/34; reported in *BMJ*, i, 1934, p. 161.

existence of discrete genes, but had gone on to demonstrate that genes, the messengers of inheritance, were carried in chromosomes lying in pairs in most cells and singly in the germ cells. The scientific community had come to some elementary understanding of the mechanisms of inheritance. After almost two years of deliberation the Departmental Committee (Brock Committee), of which R. A. Fisher was a member, completely rejected compulsory sterilisation. The Committee was unimpressed by experience in other countries. The practice in Denmark, where compulsory sterilisation was included in the penal code, was particularly deprecated. In California the scheme seemed to have been pointless; over 16,000 sterilisations had been carried out but only one in five had been on mental defectives. Elsewhere in the United States, 27 schemes had not been followed through, partly from lack of resources but mainly because of 'a lack of support for laws achieved by groups of enthusiasts not backed by public opinion'⁴¹ and the schemes had not resulted in the discharge of any significant numbers of patients from institutions. In Switzerland, where the laws had been interpreted very liberally, many operations had been carried out but as there had been no follow up studies it was impossible to draw any useful conclusions. Quite apart from the discouraging experience in other countries, the Brock Committee found that their chief objection to compulsory sterilisation was the uncertainty of diagnosis. The part played by heredity in causing mental deficiency was also uncertain; only two causes of mental deficiency – mongolism and amaurotic family idiocy – could be accurately diagnosed and were known with certainty to be genetically transmitted.

The Brock Committee concluded that 'if the test is to be the certainty with which the results of procreation can be predicted in individual cases, the case for compulsion cannot be established.'⁴² However it did consider that there might be a case for voluntary sterilisation for:

⁴¹ *Report of the Departmental Committee on Sterilisation*, op.cit.

⁴² Ibid.

- a) A person who is mentally defective or who suffers from mental disorder.
- b) A person who suffers from or is believed to be a carrier of a gross physical disability which has been shown to be transmissible.
- c) A person who is believed to be likely to transmit mental disorder or defect.⁴³

But these suggestions were made in principle only. The Committee believed that it was possible that the incidence of mental defects was indeed rising but clearly it was not rising at a rapid rate; there could be no case for immediate legislation. Research on a number of key questions would be required before any program of sterilisation could be carried out with any degree of confidence. The government, less influenced by the lack of research than by the uncertainty of public opinion, agreed. In the Commons the Parliamentary Secretary to the Minister of Health said: 'I wish an occasion would arise when birth control and the sterilisation of the unfit were more ventilated. We want guidance of public opinion on the sterilisation of the unfit.'⁴⁴ Meanwhile the government remained cautious, even on birth control. The policy of the Ministry of Health would continue to be 'that it is wrong for a maternity and child welfare centre or a clinic paid for out of public funds to be used for giving contraception advice except where further pregnancy would be injurious to health.'⁴⁵

In 1936, the Cathcart Committee was therefore under no pressure to differ from government policy. The studies recommended by the Brock Committee were still to be carried out and in Scotland eugenics and birth control were not, at that time, matters of public debate. The subject did not occupy the press. Although the Church of Scotland, in its various committees and at its General Assembly, discussed all the social problems of importance in the 1930s - unemployment, poverty, housing, immigration, emigration, malnutrition, physical and mental health - the issues of eugenics and the sterilisation of the unfit were not raised.⁴⁶ The Cathcart Committee

⁴³ Ibid.

⁴⁴ *Hansard*, ccciv, HC 17 July 1935, col. 1171.

⁴⁵ Ibid.

⁴⁶ *Reports to the General Assembly of the Church of Scotland*

was content to accept the recommendations of the Departmental Committee on Sterilisation and directed attention to two practical, relevant, and so far unanswered, questions: (1) What was the prevalence of inherited defects and weaknesses? (2) Did current conditions, including the operation of health and other social services, favour the increase of such defects?

Although experts were consulted (A. M. Carr-Saunders, Professor of Social Science at Liverpool University and F.A.E. Crewe, Professor of Animal Genetics at Edinburgh University,⁴⁷ both members of the Eugenics Society) their views lacked conviction. Without exception their statements reflected the contemporary limitations of the science of genetics.⁴⁸ The experts could only be 'inclined to a view' admitting that 'we have not much exact knowledge.'⁴⁹ Once again Cathcart preferred to rely on the few facts available rather than on expert opinion, concluding that:

1. Inherited physical diseases are few in number and of comparatively low incidence; they probably exert no significant effect on the general health of the people. Inherited weakness of constitution, not amounting to positive disease is probably more widespread and has an effect on the quality of the race.
2. Inherited mental weakness, particularly in the form of mental deficiency is a factor that must be taken into account in social policy.
3. It is impossible to say, on existing data, whether or not inherited defects and weaknesses are increasing or whether the change is taking place in the hereditary constitution of the race is for the better or worse.
4. There is need for organised research in human genetics, and in view of the importance of the subject for health policy, the promotion and encouragement of this research should be a definite function of the central department of health.⁵⁰

⁴⁷ Crewe's chief research interest was in the mechanism of sex determination. From 1929 until 1932 he had also received a research grant of £3,000 from the Bureau of Hygiene for the development of a contraceptive spermicide.

⁴⁸ Cathcart Report. Minutes of Evidence.

⁴⁹ Cathcart Report, p. 91.

⁵⁰ *Ibid.*, p. 93.

Although it was claimed in the House of Commons in 1936 that public opinion was moving in favour of eugenic measures⁵¹ the dawning of a true understanding of genetics had by then made it difficult for the scientific community to continue to share the confidence of the early eugenicists which had depended on the validity and usefulness of biometrics. In 1936, the Cathcart Committee could be even more dismissive of the potential of eugenics than the promoters of the Mental Deficiency Act of 1913, the British Medical Journal and Lord Horder in 1929 or the Departmental Committee of Sterilisation in 1933. Eugenic measures to improve the health of the nation could be rejected on scientific and practical grounds. There was no need to make any declaration on the difficult considerations of ethics and morality. Eugenics did not feature in the Cathcart Report's health program for Scotland.

Nutrition.

In 1936 the Cathcart Committee reported that even after years of industrial depression there was no evidence of widespread malnutrition in Scotland.⁵² This echoed the Ministry of Health Report in 1933 that claimed that in England and Wales 'though specially sought for, of evidence of widespread malnutrition there is none.'⁵³ However the Cathcart Committee carefully included the caveat that 'the fact that there is no evidence of widespread and gross malnutrition does not imply that there may not be a considerable amount of under or wrong feeding that does not manifest itself in specific disease or in other recognisable ways.'⁵⁴ 'It is impossible to put on record ...the state of nutrition at one examination.'⁵⁵ This was one of the questions facing the Cathcart Committee in attempting to secure the proper nutrition of the people of Scotland; how was proper nutrition to be assessed? The second question was whether a family's failure to secure an adequate diet was due to poverty or to ignorance.

⁵¹ *Hansard*, cccxiv, HC 16 July 1936, col. 2309.

⁵² Cathcart Report, p. 95.

⁵³ *Annual Report of the Chief Medical Officer*, 1932, p. 41.

⁵⁴ Cathcart Report, p. 95.

⁵⁵ *Ibid.*, p. 94.

In England and Wales, in 1933, the BMA had appointed a Committee to determine 'the weekly minimum expenditure on foodstuffs which must be incurred by families of varying sizes if health and working capacity are to be maintained, and to construct specimen diets.'⁵⁶ For the purpose of the survey, it was assumed that a family apparently healthy, working and functioning normally must be consuming a normal and healthy diet. As expected there were regional variations both in the cost of food and in dietary preferences but the committee concluded that 'the minimum cost of feeding the average adult male a reasonably varied diet sufficient to maintain health and working capacity was 5s 11d. per week.'⁵⁷ The BMA calculated that for a family of five this minimum diet would cost 23s 2d. Theoretically for such a family on benefit this would leave only 6s 1d for all other needs. On the basis that such an allocation of financial resources was impossible it was calculated that the diets of some eight million people in the United Kingdom must necessarily fail to reach the BMA's recommended minimum.⁵⁸ The BMA published these findings as a pamphlet, which sold thousands of copies within a few days. There was considerable coverage in the press and the BBC made the BMA's statement the subject of a radio programme. Under this increasing pressure, in 1935 the Minister of Health appointed a special Advisory Committee on Nutrition, of which Professor Cathcart was a member:

To inquire into the facts, quantitative and qualitative, in relation to the diet of the people, and to report as to any changes therein which appear desirable in the light of modern advances in the knowledge of nutrition.⁵⁹

In Scotland the problems of inadequate diet had been studied since the beginning of the century and different methods of investigation had been developed. By 1900 it

⁵⁶ P. Bartrip, *Themselves Writ Large; the British Medical Association 1832-1966* (London, 1996), p. 203.

⁵⁷ *Ibid.*, p. 204.

⁵⁸ *BMJ*, ii, 1933, p.1098.

⁵⁹ Cathcart Report, p. 98.

was already clear that children were growing up smaller than their grandparents and it was widely accepted that this was a consequence of poverty and urbanisation.⁶⁰ In Edinburgh, which suffered less from the effects of industrial urbanisation than many other communities in Scotland, it was observed that:

Everyone who is accustomed to pass through the slums of our city must have been struck by the large proportion of puny children and of poorly-developed, undersized adults, and the question doubtless presents itself; "How far are these conditions due to insufficient food supply and how far to general unhygienic surroundings."⁶¹

These were the opening sentences of a study of the diet of the poor of Edinburgh by Noel Paton and his colleagues in 1901. At the time vitamins were unknown⁶² and the importance of these and other essential elements in the diet had yet to be recognised. Scientific assessment of the diet was limited to the measurement of its caloric value. By this measure an adequate diet typical of a working class family was estimated to cost 16.13 shilling per week.⁶³ Food was the major item in every family's budget and the ease with which it could be provided depended on the nature of the workman's employment. Families of men in good trades, and with children's wages bringing the family income to a total of 28s to 40s a week, having paid rent (rarely above 5s a week), 1s for a funeral fund, 6d for a sickness society and other necessities such as coal at 2s 3d could afford an adequate diet. Families with a regular income of 20s to 23s a week, given careful and efficient management, could also meet the cost of an adequate diet. It was only where the husband could only find irregular work or spent more than he could afford on alcohol that families had to go without. Noel Paton

⁶⁰ A. H. Kitchin and R. Passmore, *The Scotsman's Food* (Edinburgh, 1949), p. 52.

⁶¹ D. Noel Paton, J. Dunlop and E. Inglis, *A Study of the Diet of the Labouring Classes in Edinburgh* (Edinburgh, 1901), p. 1.

⁶² Eijkman and Hopkins shared the Nobel Prize for the discovery of vitamins in 1929. Previously there had only been speculation about the possible existence of accessory food factors or 'vitamines'

⁶³ Calculated as 7.29 pence for a man, 5.62 pence for a woman and 3.54 pence per child.

concluded that it was chiefly in the homes of the feckless that the family diet was deficient in quantity.

Although the authors of the study had no knowledge of vitamins or the importance of minerals, in general terms they recognised the relationship between the content and quality of the diet and morbidity.⁶⁴ Even in the light of the limited knowledge of nutrition at that time, the quality of the diet of the poorest sections of Scottish society was unsatisfactory. The diet histories taken for the survey showed an over-dependence on potatoes, bread and jam and an almost total lack of fresh food and uncooked vegetables. Noel Paton did not attribute the poor quality of the diet directly to the prohibitive cost of a better one but believed that the quality as well as the quantity could be overcome by better education and training.⁶⁵ Nevertheless, Paton found that in 1900 nutrition was a major problem in Scotland. After investigation of diets in England, Germany, Sweden, Russia and America, Paton and his colleagues found that, even in caloric value, 'the food supply of our poorer working classes compares unfavourably ...with the diets of inmates of poor houses, prisons and pauper lunatic asylums, with the single exception of the diet allowed to the working inmates of the Scottish poor houses.'⁶⁶

Conditions for the working classes in Scotland eased to some extent in the years before the First World War. The shipbuilding, engineering and steel making industries prospered. Employment also increased in mining and the service industries from 1914.⁶⁷ But in Scotland wages continued at least 10% lower than in England⁶⁸ while food and fuel prices were higher in Scotland than elsewhere in Britain. The working class in Scotland was therefore at a disadvantage when dietary habits in the more

⁶⁴ All physicians at this time included advice on diet when prescribing for their patients.

⁶⁵ Cookery and household management had been introduced as 'domestic science' into the Scottish school curriculum in 1897.

⁶⁶ Paton et al., op.cit.

⁶⁷ O. Checkland and S. Checkland, *Industry and Ethos: Scotland 1832-1914* (Edinburgh, 1989), p. 175.

⁶⁸ *Ibid.*, p. 113.

prosperous part of the United Kingdom began to benefit from the revolution in food production at the end of the nineteenth century and from the marketing skills of the new multiple grocers. In Scotland the typical diet of much of the working class continued to be made up of white bread, margarine, tea, sugar, jam and sausages often of poor quality.⁶⁹

Wheat was plentiful and imported at low cost from North America; the introduction of roller milling⁷⁰ and improved food technology in Britain contributed to the reduction in cost. Bread could now be made as white as fashion demanded without adulteration with alum or copper sulphate. But in the new processes of milling, the wheat germ was removed from the flour and along with it all the minerals, vitamins and much of the protein. The bread on which the poor depended so heavily had become cheaper but of less nutritional value.⁷¹ Margarine had been produced in quantity in Britain from 1889. Originally made from beef fat, by the end of the century beef fat had been replaced by vegetable oils. While the new margarine looked better and tasted somewhat better, the vitamins of beef fat margarine were almost completely absent from new vegetable oil margarine produced by Van den Burgh.⁷² Meat became more affordable in Britain with the introduction of refrigerated ships after 1880; cheap beef was imported from the Argentine, lamb from New Zealand and pork from America; meat became affordable, at least on occasion, for most people.⁷³ But for the poor, meat could only be bought in its cheapest forms, as sausages or mince – both open to adulteration and ‘expansion’ to increase profit margins. Carbohydrate made up a large part of the diet. From about 1900 mechanisation, and the better understanding of the biochemistry of the processes involved, had made jam making into a large and profitable industry. Manufacturers were able to take advantage of the surplus production of the English fruit growers and

⁶⁹ Kitchin and Passmore, *op.cit.* p. 37.

⁷⁰ The first roller miller in the UK was set up in Glasgow about 1872.

⁷¹ The price of a 4lb loaf in 1832 was 10 ¼ d. In 1913 it was 5 ¾ d.

⁷² J. Burnett, *Plenty and Want, A Social History of Diet in England from 1815 to the Present Day* (London, 1966), p. 107.

⁷³ *Ibid.*, p. 105.

sales of jam became enormous, especially in the industrial areas where a sweet, highly flavoured spread was cheaper than butter and made margarine more palatable. The poor could also usually afford tea; for much of the nineteenth century tea had been an expensive luxury and often adulterated by the addition of leaves from British hedges. The introduction of lead-lined packets reduced the risk of adulteration but tea remained expensive until its marketing was taken up by the new multiple grocers. Lipton began trading tea in Glasgow in 1889 cutting the prevailing price of 2s 6d to 1s 7d.⁷⁴ The poor at Co-operative Stores could buy even cheaper brands and with tea went sugar. For the poor, sugar in its various forms provided calories and some comfort but it was of little nutritional worth.

The constituents of the less than ideal diet in Scotland - white bread, margarine, tea, sugar, jam and sausages – were not only what was cheap; they were also what was made available. Much of the food of Scotland's working class was bought at Co-operative Stores. There were 130 Co-operative Societies in Scotland, mostly in weaving and mining communities, when the Scottish Co-operative Wholesales Society (SCWS) was founded in Glasgow in 1860.⁷⁵ By 1914 the SCWS had 16 factories and 4000 employees and had become Scotland's largest food wholesaler. Retail societies, concentrated in the central belt, had a membership 470,000.⁷⁶ Customers looked to these stores for low prices (cash only) and the additional benefit of the 'dividend' which could be as much as 2s 6d in the pound and for many families the only method of saving for major purchases of any kind. The Co-operative Stores acquired a virtual monopoly in the sale of provisions to the poorer sections of society and greatly influenced the shopping habits of working class families. Unfortunately,

⁷⁴ Ibid., p. 111.

⁷⁵ J. Kinloch, and J. Butt, *History of the Scottish Co-operative Wholesale Society Ltd*

⁷⁶ T. Johnston, *The History of the Scottish Working Classes* (2nd ed., Glasgow, 1929), p. 386.

their sales of fish, fruit and green vegetables were 'negligible'.⁷⁷ The Co-operatives supplied food cheaply but did little to encourage good dietary habits.⁷⁸

The First World War brought opportunities for improvement in the nutrition of the working classes throughout the United Kingdom.⁷⁹ A Food Department at the Board of Trade was created in August 1916 and the Ministry of Food four months later. Rationing and control was introduced from 1 January 1918. Full employment meant that the working population was able to afford the food allowed by rationing.⁸⁰

The social residuum of the destitute was reduced in size and there were changes in the industrial and occupational structures which allowed casual workers and those in low-paid work on the peripheries of organised industry (outworkers, garret workers), to move to better-paid fields of employment.⁸¹

While there can be no doubt that such changes did take place there has been disagreement about the effect on the dietary habits and nutrition of the working classes. In 1918 a government committee under the chairmanship of Lord Sumner reported:

We have found in the evidence of budgets of working class expenditure that in June 1918 the working class were in a position to purchase food of substantially the same nutritive value as in June 1914. Indeed our figures indicate that the families of unskilled workmen were slightly better fed at the later date, in spite of the rise in the price of food.⁸²

In *The Great War and the British People*,⁸³ Winter has gone further, claiming not only that by the end of the War the people had healthier diets than ever before but that the

⁷⁷ J. Burnett, op. cit., p. 254.

⁷⁸ But as the Co-operative movement was closely associated with the temperance lobby, no alcohol was sold in the stores.

⁷⁹ J. E. Burnett, 'A Context for Boyd Orr: Glasgow Corporation and the Food of the Poor, 1918-1924,' unpublished paper delivered at the International Committee for Research into European Food History, Aberdeen, September, 1997.

⁸⁰ J. Burnett, op.cit., p. 218.

⁸¹ B. Waites, *A Class Society at War* (Leamington Spa, 1987), p.178.

⁸² *Report of Working Classes Cost of Living Committee*, 1918, Cmd.1918.

⁸³ J. M. Winter, *The Great War and the British People* (London, 1986).

wartime diet had provided the poorer section of the population with reserves that allowed them to withstand the deprivations of the Depression.⁸⁴ This interpretation is in line with the reassurances given by the Ministry of Health in 1932 but was disputed at the time⁸⁵ and has been disputed by historians since.⁸⁶

Whether or not there was real hunger in the 1930s is an English question. In Scotland, there was never any doubt. The evidence of sub-nutrition⁸⁷ was as visible in the 1930s as it had been to Noel Paton in 1901. (John Maclean famously said that if people could not afford the food they needed they should take it. He was jailed for sedition.) The Ministry of Food had been abolished in 1921. The many wartime government-funded organisations throughout the country, including war hospitals and canteens, which had ensured that munitions workers were properly fed no longer operated. Unemployment had increased from 2% in 1913 to over 15% throughout the 1920s. Although the collapse of agricultural prices after 1921 had lowered the cost of food the families of the unemployed or those on short-time working were unable to afford an adequate diet.⁸⁸ Almost as its last act the Ministry of Food doubled the price of milk. In the poorer areas of Glasgow milk consumption fell by a third in spite of a surplus of milk in the city.⁸⁹ It was reported that 'the very poor here never use milk as they should, but give the infants tea with toast soaked in it.'⁹⁰ Porridge made with milk and milk puddings were given up. Nursing mothers continued to breast-feed for

⁸⁴ Ibid, p. 281.

⁸⁵ H. Pollitt, in A. Hutt, *The Condition of the Working Class* (London, 1933), p. xii.

⁸⁶ C. Webster, 'Health, Welfare and Unemployment During the Depression', *Past and Present*, cix, 1985, p. 205.

⁸⁷ Sub-nutrition is distinguished from clinical malnutrition with manifest deficiency disease. 'The signs of under-nourishment in children take time to develop and are not always easily recognised though they leave scars in the constitution that last for life. Edwin Muir, *Scottish Journey* (Edinburgh, 1935), p. 135.

⁸⁸ J. E. Burnett, 'A Context for Boyd Orr,' op.cit.

⁸⁹ Webster, 'Health, Welfare and Unemployment During the Depression', op.cit.

⁹⁰ Ibid.

as long as possible. While the great influenza epidemic was raging the Independent Labour Party campaigned under banners reading '1914 - Fighting; 1920 - Starving.'⁹¹ In Glasgow, while the typical artisan, living in a room and kitchen, a member of a trade union and a provident society, and with some savings, could finance an adequate diet for his family, the very poor were close to famine. A study of the families of the unemployed and those on short working showed that over a period of two years from 1920 the caloric intake of the men had fallen from 2500 calories to 2200 calories and the weight of boys and girls had fallen by 7.5% and 7% respectively.⁹² In 1920, A. K. Chalmers, the Medical Officer of Health for Glasgow, made it clear that poverty and the lack of proper food was already leading to ill-health.⁹³ In 1921 the miners' strike made matters worse. The Scottish Board of Health reported:

The stoppage in the coal-mining industry in the spring of 1921 was responsible for great destitution in the areas affected, and the local authorities of these areas found themselves faced with the necessity of exercising their powers on a scale that had never been contemplated. Emergency arrangements for supplying food to mothers and children were rapidly made with our full concurrence.⁹⁴

In 1920 Noel Paton still argued in the *Glasgow Medical Journal*⁹⁵ that the main problem was not poverty itself but the fecklessness of the poor. But evidence to the contrary was growing stronger. In 1923 the Scottish Board of Health, in reporting that death rates of children were higher than in most parts of England, attributed the difference in part to climate and housing conditions but also to poor feeding.⁹⁶ In

⁹¹ G. Aldred, *John Maclean* (Glasgow, 1940), p. 47.

⁹² A. Tully, 'A Study of the Diet and Economic Conditions of Artisan Families in Glasgow', *Glasgow Medical Journal*, ci, 1924, p. 1.

⁹³ A. K. Chalmers, 'A Complete Health Service'. Unpublished lecture given in 1920, quoted by J. E. Burnett, op.cit.

⁹⁴ *Annual Report of the Scottish Board of Health*, Cmd.1697, 1921, p. 47.

⁹⁵ D. M. Paton, 'Physiology: The Institutes of Medicine,' *Glasgow Medical Journal*, xii, 1920, p. 321.

⁹⁶ *Annual Report of the Scottish Board of Health*, Cmd. 2156, 1923, p. 50.

1926 the Empire Marketing Board made a grant to John Boyd Orr at the Rowett Institute to demonstrate the nutritive value of milk.⁹⁷ A committee was formed, under the chairmanship of Sir Leslie Mackenzie, to supervise the scheme for the Scottish Board of Health.⁹⁸

This was not a survey as organised by the BMA in 1933. This was a clinical trial in which, as in all Boyd Orr's investigations, sound nutrition was defined as a state of well-being such that could not be improved by change in the diet. The trial was carried out in the seven largest towns in Scotland and in Belfast. The results were published in the *Lancet*⁹⁹ and *British Medical Journal*¹⁰⁰ in January 1929. It was demonstrated that the children who were given free milk 'showed a marked improvement, in weight and height, and by better general condition.' The Ministry of Health was sceptical, claiming that the benefit to the children came from the supervision and general regulation of their lives during the period of the trial and not from the nutritional supplement. However in 1931, Tom Johnston, the Under-Secretary for Scotland in the Labour Government arranged for a further trial in Lanarkshire to meet this objection.¹⁰¹ On the evidence of these trials, Walter Elliot, the Conservative Minister of Agriculture in the National Government, successfully introduced a Bill in 1934 to allow local authorities in Scotland to provide cheap milk for all school children.¹⁰²

In 1934 the Rowett Institute received a grant from the Carnegie Trust 'to estimate the diets of different classes, including the whole population, according to family income.'¹⁰³ The survey was promoted by Walter Elliot, and supported by the Agricultural Board and the Linlithgow Committee on the Import of Food¹⁰⁴ and was

⁹⁷ J. Boyd Orr, *As I Recall* (London, 1966), p. 110.

⁹⁸ *Ibid.*, p. 114.

⁹⁹ *Lancet*, i, 1929, p. 41

¹⁰⁰ *BMJ*, i, 1929, p. 23.

¹⁰¹ Boyd Orr, *As I Recall*, op.cit.

¹⁰² *Ibid.*, p.115.

¹⁰³ J. Boyd Orr, *Food, Health and Income* (London, 1937)

¹⁰⁴ Boyd Orr, *As I Recall*, op. cit., p. 115.

carried out by John Boyd Orr¹⁰⁵ in centres in England as well as Scotland. This survey was again conducted in accordance with Boyd Orr's usual practice.

Instead of discussing minimum requirements, about which there has been so much controversy, this survey considers optimum requirements. Optimum requirements are based on the physiological ideal, which we define as 'the state of well-being such that no improvement can be effected by change in the diet.' The standard of adequacy of diet adopted is one which is designed to maintain this standard of perfect nutrition.¹⁰⁶

The survey showed that this standard was not being reached by families in which the income per week was less than 20s; such families made up 47.1% of the population.¹⁰⁷ 'Complete adequacy is almost reached' by the families - 25.3% of the population - with a weekly income between 20s and 30s. For more affluent families 'the diet has a surplus of all the constituents considered.'¹⁰⁸

This report was rejected by Kingsley Wood, the Minister of Health, who continued to insist that such sub-nutrition as existed could not be attributed to poverty since poverty had been effectively abolished by the existing state welfare schemes. Official support was withdrawn from the Rowett Institute. It was even suggested that the medical members of the research team might be reported to the General Medical Council and removed from the Medical Register for unethical conduct in publishing work that had been unfairly represented for political ends. Because of this threat, co-authors withdrew and the results were issued under Boyd Orr's name alone and published by Harold Macmillan, not only chairman of Macmillan and Company but also MP for Stockton who was greatly concerned about the plight of the poor in his own constituency. *Food, Health and Income* went through three editions and attracted international interest. The Department of Health accepted its findings that:

¹⁰⁵ Professor Cathcart collaborated in this trial. J. Brotherston, 'The Development of Public Medical Care,' in G. McLachlan (ed.) *Improving the Common Weal* (Edinburgh, 1987), p. 82.

¹⁰⁶ Boyd Orr, *Food, Health and Income*, op.cit., p. 11.

¹⁰⁷ Ibid., p. 67.

¹⁰⁸ Ibid., p. 55.

- 1.The national dietary contains sufficient energy-giving foods for the whole population. All but a small fraction of the population are obtaining as many calories as they require.
- 2.There is no aggregate deficiency of fat. But there is a shortage of it in the poorest.
- 3.There is a deficiency of milk in the diet of a large section of the population.
- 4.It is probable that insufficient fruit and vegetables are eaten. More potatoes should be eaten, replacing some of the sugar and highly milled cereals in the ordinary diet.¹⁰⁹

The Carnegie Trust provided £15,000 for a further more comprehensive study that included medical examination of the families in addition to the review of their diets. The results were published in the *Lancet*¹¹⁰ and *British Medical Journal*¹¹¹ in 1940. In a preface to these articles Lord Woolton, the Minister of Food, acknowledged that this survey had allowed him to develop 'a food policy based on the scientific knowledge of those engaged in the study of nutrition and biochemistry, translated in terms of a dietary restricted by wartime conditions of supply.'

Professor Cathcart, as a member of the Government's Advisory Committee on Nutrition, had played an important part in the formulation of wartime food policy and the Cathcart Committee had carried out its own investigations and supplied the Advisory Committee with the results. But in 1936, the Cathcart Committee's comments on the nutritional problems in Scotland were careful and non-committal on what it accepted as the 'major issue of controversy on this subject of nutrition' - whether improvement was to be brought about 'by economic changes or by education.'¹¹² The Cathcart Committee 'was of the opinion that one of the most valuable means of making good the deficiencies of home feeding was the provision of free or cheap milk and meals to school children' but at the same time the Committee

¹⁰⁹ *Annual Report of the Department of Health for Scotland, 1937*, Cmd.5713, p. 52.

¹¹⁰ *Lancet*, i, 1940, p. 871.

¹¹¹ *BMJ*, ii, 1940, p. 217.

¹¹² Cathcart Report, p. 97.

claimed that 'there is abundant room for practical education of the people on the purchase and preparation of food.'¹¹³

The Cathcart Committee did not set out a plan to overcome the acknowledged deficiencies in the diet of the mass of the people in Scotland. It decided that it should be left to the Advisory Committee on Nutrition to decide whether 'any considerable departure from national health policy would be justified.'¹¹⁴

In this as in other matters, the Cathcart Committee wished to deviate as little as possible from British policy. But by including a section on nutrition in its Report, the Cathcart Committee ensured that in future, problems of nutrition would be kept under review and would feature in all subsequent reviews of health and health policy. 'An adequate supply of food in the form of a well- balanced mixed diet is the most important single factor in the maintenance of health.'¹¹⁵ However, it is undeniable that the Cathcart Report missed the opportunity to draw attention to the particular and persisting problems in Scotland. Relative poverty, high food prices, hidebound marketing practices, long established habits and housing with inadequate equipment and services for preparation of meals¹¹⁶ were all factors which continued to prejudice the diet of the majority of the Scottish people in 1936 and for many years after the introduction of the National Health Service.

Health Education

It was central to Cathcart's plan for the future that every member of society should be able to play a full part in maintaining his own health. In the 1930s it was

¹¹³ Ibid. p. 98.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Domestic services such as kitchen stoves and sinks were not fully surveyed until the census of 1951.

generally agreed that public ignorance regarding matters of health, especially in regard to dietetics, child welfare and nursing, is a serious obstacle to the efficient functioning of the medical services.¹¹⁷

Cathcart was confident that considerable improvement of public understanding of health had come about as the result of the sanitary measures introduced in the previous century.¹¹⁸

Sanitation may in itself be a public educator. The introduction of a public water supply may have effects on the population concerned far beyond its results in an adequate provision for the purposes of drinking and personal cleanliness. In such matters it is not possible to become accustomed to decency in one aspect of life without attaining to a wider sense of personal and communal responsibility.¹¹⁹

Cathcart claimed that this more enlightened 'outlook of the people' was the result of the improving experience of better sanitation, better housing, less poverty and the constructive use of increased leisure. Personal hygiene had also been influenced by general practitioners, the hospital service, the school medical service and the various welfare organisations. Voluntary organisations had made useful contributions – boy scouts, girl guides, youth hostels, folk dancing and boys' camps. The effect of experience and example had been cumulative. However there was still an urgent need for further improvement. There was a frustrating gap between what was known and what was practised – in nutrition, dress, recreation, the management of the home, and the parental care of children.

In 1911 the National Insurance Act had empowered Insurance Committees to spend money on health education; a few of these bodies had organised public lectures and issued pamphlets to the public but the majority had not. In England in 1927, the Society of Medical Officers of Health, funded by a number of voluntary bodies and by local authorities, set up the Central Council for Health Education. Its aims were:

¹¹⁷ Evidence to the Cathcart Committee by the Scottish Branch of the Society of Medical Officers of Health (Scottish Branch). Cathcart Report, p. 104.

¹¹⁸ *Ibid.*, p. 43.

¹¹⁹ *Ibid.*

1. To promote and encourage education and research in the science and art of healthy living and to promote the principles of hygiene and encourage the teaching thereof.
2. To assist and co-ordinate the work of all the statutory bodies in carrying out their powers and duties under the Public Health Acts and other statutes relating to the promotion or safeguarding of Public Health or the prevention or cure of disease in so far as such work comprises health education and propaganda.¹²⁰

The Central Council organised health weeks and propaganda campaigns but most doctors and teachers remained unconvinced that they served any useful purpose.¹²¹ (No similar body had been set up in Scotland.) In 1927 the British Broadcasting Corporation made its brief contribution to health education. A series of lectures on 'Health in the Home' were broadcast in March and April and published first in the *Listener* and later as a pamphlet.¹²²

Cathcart rejected these methods for health education:

Health education is frequently taken to mean propaganda by lecture, leaflets and the like. These methods have their place, but, at present, they seldom reach the section of the population that has the most need of instruction... Unless they fit into a larger scheme, they may do harm. Health propaganda tends frequently to concentrate on disease rather than on health. While propaganda against particular diseases (e.g. venereal diseases, tuberculosis, cancer, etc) has achieved excellent results, it may have had the effect of creating unnecessary fears. ... Certainly, health propaganda is always in danger of producing some of the harm that is done by the type of advertising for patent medicine that deliberately plays on fear... propaganda will carry the minimum of risk if it is subordinate to a satisfactory scheme of health education.¹²³

Cathcart stressed that health education should not be prescriptive but should aim at stressing the advantages of healthy living.¹²⁴ 'Health is not a negative state, it

¹²⁰ I. Sutherland (ed.), *Health Education* (London, 1979), p. 3.

¹²¹ *Ibid.*, p. 13.

¹²² M. E. Green, *Health in the Home* (London, 1927).

¹²³ Cathcart Report., p.106.

¹²⁴ *Ibid.*

involves more than the mere absence of disease.'¹²⁵ 'It is obvious that there are many people who, despite the absence of any signs of disease, nevertheless fail to reach a satisfactory standard of health and usefulness or to the enjoy the sense of well being that might be reasonably expected.'¹²⁶ The Report quoted Sir Leslie Mackenzie:

Subjectively the healthy man has a feeling of satisfaction and ease in his activities, a general feeling of well being, freedom from the sense of effort, freedom from the sense of environmental oppression, freedom from the feeling of being oppressed by his work, freedom from uncontrollable moods and tempers.¹²⁷

In its evidence to the Cathcart Committee, the Scottish Committee of the BMA urged the promotion of this sense of well being. It drew particular attention to the part that education could play in meeting the new problems of leisure, not only the increased leisure which came with the reduction in the working week to 48 hours, but 'especially when leisure is enforced by lack of employment and carries with it the special strains caused by economic anxiety.'

Leisure is an evil for those who have no capacity for using it, and though the questions relating to leisure are not entirely medical, the doctor best knows the evil influence upon health, especially mental health, of the excess of leisure in unemployment and also the lack of tastes that make leisure healthful. Since it is generally accepted that the future will show an increase of technological unemployment it is necessary to state from the medical aspects the issues involved.¹²⁸

It was proposed that the leisure time of young people could easily be taken up in athletic and other physical activities. For other adults the educational system should provide instruction in handicrafts and gardening. Since these activities would not usually fill all leisure time, the educational system should also foster the taste for new

¹²⁵ Ibid., p.107.

¹²⁶ Ibid., p.106.

¹²⁷ Cathcart Report, p. 107. In 1946 the World Health Organisation expressed the same ideas but more succinctly. 'Health is a state of physical, mental and social well-being, and not simply the absence of disease or infirmity.'

¹²⁸ Ibid. p. 105.

interests - literary, musical, dramatic and artistic. Cathcart suggested that that it was the lack of such cultural interests that, in the past, had 'favoured the more anti-social alleviation of leisure - intoxication and methods of extraneous stimulation.'¹²⁹

The evidence submitted to the Cathcart Committee emphasised the importance of health education and recommended that responsibility should be with the education authorities. While both the general practitioners and the Department of Health clearly had some part to play, there was general agreement that the overall responsibility for health education should lie with the Department of Education and instruction on health related subjects should be included in the school curriculum.

The Cathcart Report set out a very detailed scheme clearly based on the Committee's assessment of the progress already made. It was confident that over the previous hundred years 'the habits and outlook of the people'¹³⁰ had been changed by their experience of improved sanitation and their increasing familiarity with a higher standard of living, supplemented by practical guidance from the better informed – including doctors, welfare services, voluntary bodies. Cathcart now recommended that health education should continue on the same principles. It was particularly important that the school environment should be improved and more facilities should be provided for exercise, sport and the development of ideas and skills that might later be useful for adult leisure.

Instruction on healthy living should begin in infancy with informal day to day guidance to develop good healthy habits. Until the age of twelve 'formal health lessons are unnecessary; the lessons should be incidental to other school subjects.'¹³¹ After the age of twelve, incorporated in the teaching of biology, there should be systematic instruction to provide 'a sufficient knowledge of the working of the human body to enable them to realise the value of health.'¹³² In the senior classes every girl was to be given 'some practical instruction in plain household cookery, food values

¹²⁹ Ibid.

¹³⁰ Cathcart Report, p. 42.

¹³¹ Ibid., p.108.

¹³² Ibid.

and economic buying' and, since in the interval between school and marriage many would have forgotten what they had been taught, local authorities should provide courses for women on cookery and in baby and child management.

The changes recommended in the curriculum required only some adjustment and extension of existing arrangements. The recommendations for improvement in the school environment, at least as important to Cathcart as changes in the curriculum, were much more demanding. Many new nursery schools would be needed. Most day schools fell short of the required standard; the ideal for a school was a well lit, well heated and well ventilated building on a spacious, airy site, with ample space for play and organised games, and made attractive with trees, grass plots and flowers. The classrooms should have the maximum amount of sunlight, should be tastefully furnished and decorated and should be of good size to allow free movement and to discourage the spread of infection. Cloakrooms should be large, well ventilated and with drying facilities for wet clothes. All schools should have adequate provision (including showers) for regular physical training. As organised games provided a valuable form of physical and social training, they should be compulsory. All new schools should be built on sites large enough to provide ground for the playing of organised games as a part of the school curriculum. In schools where children did not go home at midday a hot meal should be provided 'in seemly and comfortable conditions.'¹³³ For children who lived at some distance from school there should be a properly staffed and equipped hostel.

Cathcart acknowledged that children with disabilities would be unable to take part in this standardised programme for schools. Some 6,000 children were already educated in special schools for the blind, the deaf and those with other chronic ailments. Many more special schools were required. Similarly there were only 5,000 places for mentally defective children; day schools or special classes were required for many more.

¹³³ Cathcart Report, p. 108.

The Cathcart Committee proposed that health education should be continued into adult life as a primary function of the Department of Health. In co-operation with the Department of Education and the Local Authorities, a separate section should be set up in the Department to take overall responsibility for health education. Valuable work was already being done in health education in Scotland through a number of special agencies, for example the National Association for the Prevention of Tuberculosis. In England the work of all such organisations was co-ordinated by the Central Council for Health Education; a similar body was needed in Scotland.

The Committee also recommended that the Teacher Training Colleges and Scottish Universities should play their part. Teacher training should be revised to include more instruction in biology, physiology and hygiene and more opportunity for the practice of physical education and hygiene. At the universities, every student should be medically examined on entry and should be expected to take part in some form of physical training as a normal part of the curriculum. 'We consider this necessary for the proper mental and physical development of all students, who in after life may become leaders in the community.'¹³⁴

The Cathcart Committee had in mind a new and important role for health education. It was to have more ambitious aims than the correction of the 'ignorance and fecklessness'¹³⁵ of the poor.

The aim of health education should be to train each individual to adopt such a way of living as will enable him to derive full enjoyment from the exercise of his faculties not solely for his own benefit, but also for the benefit of the community. There is an essential unity of life, and the physical should be interpreted in association with the intellectual and emotional; but the physical aspect is fundamental.¹³⁶

¹³⁴ Ibid., p. 115.

¹³⁵ T. C. Smout, *A Century of the Scottish People* (London, 1986), p. 128.

¹³⁶ Cathcart Report, p. 107.

Health education was to be a cornerstone of the health policy advocated by the Cathcart Committee. The ideas behind Cathcart's proposals were not new. There were distinct echoes of Juvenal – *orandum eat ut sit mens sana in corpore sano*. Cathcart's originality was in attempting to bring health education to the forefront of national health policy and to contend that the necessary education should be by precept and practice and not by exhortation and propaganda.

In the 1930s Cathcart's proposals were not well received. It has been claimed that Whitehall found the emphasis on physical activities and training in Cathcart's scheme to be too close to the fascist methods then practised in Germany and therefore inappropriate for Britain.¹³⁷ Government preferred to rely on exhortation and propaganda. In 1937 Neville Chamberlain, recently Minister of Health and now Prime Minister, launched the first national health education campaign. This was carried out by the distribution of leaflets, by posters and by lectures, exhibitions and film shows.

In the first decades of the National Health Service, health education was given a very low priority. The Health Education Council was not formed until 1968. For complex reasons including conflicts of political and other vested interests, the Health Education Council was disbanded in 1987 to be replaced by the Health Education Authority. These bodies continued to adopt the methods – leaflets, posters and films – rejected by Cathcart. Their effectiveness is unproven; many in the medical profession remain very sceptical. Cathcart's approach to health education has never been put to the test.

The Environment

The Cathcart Committee was satisfied that, since the middle years of the nineteenth century, and particularly in the last thirty or forty years, great improvements had been made in the general sanitary condition in Scotland. The Committee was confident that these reforms had not only provided greater protection against disease but, by their

¹³⁷ M. Grant, 'The National Health Campaigns of 1937-8' in D. Fraser (ed.), *Cities, Class and Communication: Essays in Honour of Asa Briggs* (London, 1990), p. 217.

success, had created an increasing public demand for even further improvement. Since public health arrangements had been reviewed by the Department of Health for Scotland in 1929, the Cathcart Committee considered it 'unnecessary to attempt anything approaching a sanitary survey of Scotland.'¹³⁸ The Report did not dwell on the great problems that had faced the Department of Health since 1929, and which had only been overcome with the financial support of the Unemployment Grants Committee and the Commissioner for Special Areas. The Cathcart Committee concentrated on the important amendments to the legal, financial and administrative arrangements that were clearly necessary if the environmental services were to play their proper and effective part in the national health policy.

After a long history, by 1930 the public services of water supply, drainage and water borne sewage were regulated in the burghs by the compulsory provisions of the Burgh Police (Scotland) Act of 1892 and in the counties by the enabling provisions of the Public Health (Scotland) Act of 1897. Both Acts allowed for the creation of Special Districts – parts of an authority's area of responsibility carved out to provide a defined service to meet particular local circumstances. While the Burgh Health (Scotland) Act discouraged the formation of Special Districts in the towns except in most unusual circumstances, the Public Health (Scotland) Act encouraged the formation of Special Districts in rural areas. The legislative provision for the formation of Special Districts had initially been resisted by the local authorities, particularly by the county authorities in 1897.¹³⁹ But by the 1930s Special Districts were well established and providing the essential services in the majority of the larger villages and the most populous parts of rural Scotland. Cathcart found that this complex administration gave rise to difficulties in financing schemes that were clearly necessary and made it impossible to construct comprehensive schemes to serve whole counties or regions to maintain universal standards.

¹³⁸ Cathcart Report, p. 116.

¹³⁹ T. Ferguson, *Scottish Social Welfare* (Edinburgh, 1958) p. 196.

In 1929 the Department of Health for Scotland had at once been faced with a crisis in water supply. It was a year of exceptional drought causing water shortages in many of Scotland's hundreds of special water areas and even in a number of the moderate sized burghs. Most of these water authorities had been aware of their deficiencies in supply and the risk of recurring failures for some years, but schemes for improvement had been hampered by inability to meet the cost, by difficulties in acquiring water rights or by the lack of co-operation from neighbouring authorities. The full extent of the resulting deficiencies was unknown in 1929 since each water authority was autonomous and reports to the Department of Health were not required unless an application was being made for a grant from Treasury funds.

In 1930 the Department therefore instituted a survey of Scotland's 530 water authorities (burghs and special districts). It soon became clear that in many areas, while the water supply was adequate for current rates of consumption and in normal weather conditions, there was no margin for periods of drought or for increase in demand; in other areas where the water supply was polluted there was no adequate mechanism for making it safe. In several areas water mains were beginning to deteriorate and their carrying capacity was being eroded.¹⁴⁰ When completed in 1931 the survey found that water supply was unsatisfactory in 47% of Scotland's local authority areas.¹⁴¹ Some authorities had already begun to finance schemes of improvement supported by grants from the Unemployment Grants Committee. Following the setting up of the Scottish Committee on Unemployment Relief Works the Department encouraged local authorities to apply for further support. By 1931 grants totalling £960,000 had been agreed in support of 153 water supply schemes.¹⁴² Further schemes were agreed in 1932. However August 1933 brought a further period of exceptional drought and by January 1934 the water supply had failed again in 31% of the Scotland's burghs and 26% of the Special District in rural areas.¹⁴³ As the

¹⁴⁰ *Annual Report of the Department of Health for Scotland*, 1930, Cmd. 3860, p. 22.

¹⁴¹ *Annual Report of the Department of Health for Scotland*, 1931, Cmd. 4080, p. 21.

¹⁴² *Ibid.*, p 20.

¹⁴³ *Annual Report of the Department of Health for Scotland*, 1933, Cmd.4599, p. 28.

drought continued into 1934 in many areas emergency measures were still in force to limit water consumption.

In its Annual Report in 1934 the Department of Health for Scotland set out the lessons learned from the drought.¹⁴⁴ In part the problem was seen to lie in the increasing consumption of water. In 1890, 10 gallons per head per day had been considered sufficient for domestic purposes and by 1898 this had risen to 15 gallons. In 1934 the burghs were providing up to 40 gallons per day yet demand was still growing. Although Scotland's water resources were more than adequate the system of distribution was clearly unsatisfactory. In some areas where the water reserves should have been adequate, supplies had failed because of leaking reservoirs and defective pipes. However the chief fault was the individualism of the local authorities in their approach to water supply, with each local authority seeking to solve its own problem. This resulted in a very uneven pattern of supply in which one area might have a more than sufficient supply while its immediate neighbour was in difficulty.

In February 1934 the Cathcart Committee presented an Interim Report on the water supplies.¹⁴⁵ The Committee confirmed that, while the natural water resources in Scotland as a whole were ample for all foreseeable needs, in many areas supplies were either inadequate in quantity or fell below acceptable standards of purity. These deficiencies were judged to be due primarily to the administrative system under which water was supplied in Scotland. In 1936 the Committee repeated its recommendation that a technical survey should be undertaken at once of the water resources of Scotland and that a comprehensive inquiry should be held into the whole question of water supplies with the objective of securing more effective use of resources.¹⁴⁶ Cathcart recommended that, in line with a developing policy for Great Britain as a whole,¹⁴⁷ water supplies should continue to be the responsibility of the local

¹⁴⁴ *Annual Report of the Department of Health for Scotland, 1934*, Cmd.4837, p. 41.

¹⁴⁵ *Report of the Committee on Scottish Medical Services- Interim Report- Water Supplies*, HMSO, 1934.

¹⁴⁶ *Annual Report of the Department of Health for Scotland, 1934*, Cmd. 4837, p. 40.

¹⁴⁷ Cathcart Report, p. 122.

authorities. But in the interest of economy and efficiency it was recommended that Special Districts should be abolished and the burgh and county authorities should be encouraged to co-operate. (Three members of the Committee recorded their minority view that that 'to rely on co-operation is to ignore the lessons of history in local government.')

¹⁴⁸ In 1936 the Report made no reference to the severity of the crisis that had provoked its Interim Report or the extent of the deficiencies recorded by the Department of Health in its Annual Reports since 1929. The Report also failed to mention that Scotland had only been rescued from the water crises of 1929 and 1933/34 by support from the Unemployment Grants Committee and the Commissioner for Special Areas.

In 1929 the Department of Health had also found serious inadequacies in drainage and sewage disposal. In many villages, especially in the mining areas where the number of inhabitants was already diminishing, arrangements for sewage disposal remained primitive and the houses were served only by dry closets and ashpits. Since the necessary improvements would require rate increases of up to 6s 10d in the pound (rates in some cases were already over 20s in the pound) local authorities were unwilling to impose charges which the declining local population could not afford.¹⁴⁹ Falkirk was one of several towns where satisfactory sewage schemes had been long delayed by disputes between town and county councils over the distribution of costs of a combined scheme. Kilmarnock was a notorious example of a town that for many years had discharged its untreated sewage directly into the local river, improvements had been long delayed because of the projected cost to the ratepayers (a rate increase of 1s 6d in the pound was unacceptable). Some county areas, notably the Vale of Leven, had long standing problems of pollution caused by uncontrolled dumping of sewage but could not find an agreed solution among the various responsible local authorities. (A scheme of improvement for the Vale of Leven had also met opposition from local anglers and from local landowners on amenity grounds.)

¹⁴⁸ Ibid. p. 363.

¹⁴⁹ *Annual Report of the Department of Health for Scotland*, 1929 Cmd. 3529, p. 36.

Similar problems were widespread across both urban and rural Scotland. New installations had not kept pace with the increasing needs of local communities. In the 1930s this was compounded by the deterioration and inadequacies of sewage works of antiquated design, installed in the previous century. Some improvements were made possible when, in the worst years of the Depression, financial support was offered by the Unemployment Grants Committee. By 1931 150 drainage and sewage purification schemes had already been financed by grants totalling £1, 653,387.¹⁵⁰ Further support came in 1934 under the Special Areas (Development and Improvement) Act, 1934. By 1936 the Special Areas Fund had provided £1, 590,225 toward the cost of sewerage and sewage disposal works.

In 1936 the Cathcart Committee reported that ‘ the cities and the larger towns have reasonably adequate drainage and sewerage, but in many other parts of the country the position is unsatisfactory’.¹⁵¹ However the Committee again failed to draw attention to the full extent of the deficiencies reported by the Department of Health since 1929 or acknowledge that the improvements achieved since 1931 had only been made possible by the unusual and presumably temporary assistance of the Unemployment Grants Committee and the Special Areas Fund.

Cathcart’s proposals for the future aimed at a better definition of responsibilities and increased central control. The duty of local authorities to provide sewers was to be limited to public sewers; all other sewer for the drainage of land or buildings belonging to a person were to be provided by that person. The existing statutory powers to require houses to have indoor water closets were to be enforced. The statutory obligation on towns to provide drainage was to be enforced equally in counties and special districts. The Department of Health was to have powers of compulsory combination to enforce co-operation between local authorities to ensure economical and efficient administration. Major projects such as the construction of trunk sewers and sewers discharging into the sea were to be subject to the approval of

¹⁵⁰ *Annual Report of the Department of Health for Scotland, 1934*, Cmd. 4837, p. 20.

¹⁵¹ Cathcart Report, p. 122.

the Department. Borrowing by local authorities for major projects was also to be by consent of the Department. However finance was to remain the responsibility of the local authorities; it was proposed that the existing limit on the amount of the annual rate that could be levied for water and drainage (4s in the pound in burghs, 3s in special areas, no limit in counties) should be abolished.

Cathcart's most controversial proposals related to the abolition of Special Districts. Abolition was resisted by many local authorities, especially those which carried no debt and were unwilling to share the financial burden of the counties. For their part, county authorities were unwilling to accept the responsibility to provide expensive services for every isolated house or farm. In spite of these objections some members of the Committee thought it necessary to abolish Special Districts completely.¹⁵² In the event a compromise was reached; the Committee proposed that while all existing special districts were to be abolished, the Department of Health should retain the power to sanction new special districts 'in exceptional circumstances'.¹⁵³

On the public services of cleansing, scavenging and nuisance removal the Committee was satisfied that the public services in the burghs and special districts had recently been much improved and were now satisfactory. In the county areas where no services existed it was judged to be sufficient that any 'objectionable feature'¹⁵⁴ could be dealt with as a public health nuisance. Cathcart therefore made only modest recommendations for change. Since the existing legislation had become outmoded it was recommended that it should be replaced by a new modern code. This was to be based on scheme successfully introduced in Edinburgh in 1933. It was recommended that new powers should be given to the Department of Health to supervise the implementation of this code across Scotland. To assist local authorities

¹⁵² Cathcart Report, p. 363. Reservation Regarding Local Administration of Water Supplies and Drainage.

¹⁵³ Ibid., p.121.

¹⁵⁴ Ibid., p.128.

in financing new practices they were to be allowed to make a charge for removal of all trade waste.

Cathcart gave greater attention to the control of atmospheric pollution. In 1920 the Committee on Smoke and Noxious Vapours Abatement¹⁵⁵ had produced statistical proof of the close relationship between the death rate and atmospheric conditions, especially between deaths from pulmonary and cardiac disease and the intensity and duration of smoke fogs. Dr. Chalmers, the Medical Officer of Health for Glasgow had also pointed out that these dense fogs usually occurred at times when the incidence of influenza, bronchitis, measles and whooping cough was high and substantially increased the risk of the death from the complication of pneumonia. The existing legislation of smoke abatement in Scotland was diffuse- under the Smoke Abatement Acts of 1857, 1861 and 1865, the Burgh Police (Scotland) Act, 1892, and in Section 16(9) and (10) of the Public Health (Scotland) Act of 1897. Administration was in the hands of the town councils of the burghs and the county councils in the rural areas. In the 1930s the Smoke Abatement Acts, intended to apply to all burghs with populations over 2000, were seldom used. With the exceptions of Glasgow, Edinburgh, Dundee, Aberdeen and Greenock that had their own statutory powers, the Public Health (Scotland) Act, 1897 applied to landward as well as burgh areas. However by the 1930s the Burgh Police Acts had been undermined by the Public Health Act which placed the onus on the local authority to prove that the person using the furnace was not using the best practice. The Acts were therefore of little value and there was no co-ordination on policy even between neighbouring local authority areas. Only in Glasgow and a few of the other large burghs was there any real attempt being made to control atmospheric pollution. Even in these large towns (except Glasgow) mines and iron and steel works were exempt from regulation. None of the existing legislation applied to domestic chimneys although in the 1930s domestic coal

¹⁵⁵ *Report of the Committee on Smoke and Noxious Vapours Abatement, Interim Report*, HMSO, 1920.

consumption exceeded the consumption of heavy industry. (and continued to rise to a peak in 1937).¹⁵⁶

Cathcart proposed that there should be new legislation on smoke abatement applicable to counties as well as burghs, co-operation between local authorities should be assured and that the legislation should be more rigorously applied, with increased penalties. While, in general, the exception for mines and iron and steel works should continue, the Department of Health should have powers to exclude any of the processes used from that exception. Cathcart also proposed that the definition of smoke should be expanded to include soot, ash, and particulate matter.

Cathcart drew attention to a new problem. Since the end of the war, the building of electricity power stations had resulted in the release of great quantities of sulphur gases.¹⁵⁷ Although the sulphuric acid had its greatest effect on stone work, iron work and plant life, it could also be assumed to have some effect on the health of the people who lived in the neighbourhood of these installations. It was therefore proposed that sulphur gases should be regulated by a new Act to be administered by the Department of Health.

The Cathcart Report made a strong case for the regulation of industrial smoke. Although domestic smoke was 'the greater part of the nuisance'¹⁵⁸ the Cathcart Committee believed that 'the solution of that problem depends upon efficient substitutes for ordinary coal and on public education in the advantages of their use.'¹⁵⁹

The Committee made no new proposals for public supervision of food for the protection of health. The supervision of meat and milk supplies was accepted as satisfactory and it was recommended only that in the future Scotland should be guided by British legislation and in particular the recommendations of the Inter-Departmental Committee on Food Laws.¹⁶⁰

¹⁵⁶ *Annual Abstract of Statistics*.

¹⁵⁷ A plant consuming 1,000 tons of coal released 30 tons of sulphuric acid into the atmosphere.

¹⁵⁸ Cathcart Report, p. 137.

¹⁵⁹ *Ibid.*

¹⁶⁰ *Report of the Inter-Departmental Committee on Food Laws*, 1934, Cmd. 4564.

The Cathcart Committee's recommendations for the reform of the public works, services and supervision for the maintenance of a healthy environment were modest. The burghs and county councils were to remain the responsible authorities but their areas of responsibility were to be more clearly defined by the virtual abolition of Special Districts. The financial difficulties of local authorities were to be relieved at least in part, by easing the limits previously imposed on rates and by allowing charges to be made to commercial users. Central supervision by the Department of Health was to be increased, to control levels of expenditure, to promote co-operation between local authorities and to ensure a more even provision of services across the country.

Housing

Cathcart accepted that in Scotland housing was a longstanding and major problem and in the 1930s, the management of housing was the most crucial of the environmental services. In the nineteenth century the state had accepted some responsibility for the elimination of unfit dwellings but had played an insignificant part in providing suitable housing for the poorer members of society. From the First World War a new housing policy had emerged and the Cathcart Committee was confident that the housing programmes already in place by the 1930s were raising the standard of living of a large part of the population and making a substantial contribution to an improvement in public health and well-being.¹⁶¹ In this confidence the Report, while recognising the 'magnitude of the problem',¹⁶² that remained in Scotland, devoted little space to the discussion of further plans for its solution.

Although in the first years of the century government had been principally concerned with the removal of pestilential slums and the improvement of sanitation, the Housing and Town Planning Act of 1909 had given local authorities optional powers to set down plans for new developments, to design street layouts, to restrict

¹⁶¹ Ibid., p. 146.

¹⁶² Ibid., p. 143.

building densities and to acquire and set aside land for development. However the construction of new houses was left almost entirely in the hands of private enterprise. The Act included some obligation on local authorities to provide houses for those displaced by any destruction of slums but most local authorities proved reluctant to take on these new responsibilities and few development schemes were submitted for government approval before the First World War.¹⁶³ In 1914 a memorandum of the Local Government Board for Scotland recognised that there was not only an overall and increasing need for more houses but also that the existing slum clearance programs would fail ‘unless there is other proper accommodation for the persons displaced.’¹⁶⁴ The local authorities in Scotland had again failed to respond.¹⁶⁵

The issue was forced by the military requirements of the war. Houses were required for the large number of munitions workers and other civilians needed for war work. At Rosyth, the Admiralty sponsored a public utility society, the National Housing Company, to house ‘in a manner that shall secure to the future community, at reasonable rentals, model standard of health and comfort.’¹⁶⁶ This wartime initiative proved to be a watershed in the provision of housing in Scotland, demonstrating how many houses local authorities could build in a short space of time and the standards in housing that could be achieved. The shift towards local authority housing received further impetus in 1915. In response to the serious and potentially dangerous unrest in Glasgow provoked by wartime inflation in rents, the Increase of Rent and Mortgage Interest Act limited rents to the levels which had prevailed at the outbreak of the war. Rent control continued after the war¹⁶⁷ and proved to be an effective disincentive to house building. Since this disincentive had greater effect on private builders than on local authorities, the building of houses for the working class in Scotland became almost exclusively the province of the state.

¹⁶³ T. Begg, *Housing Policy in Scotland* (Edinburgh, 1996), p. 15.

¹⁶⁴ Ibid.

¹⁶⁵ In 1914 Dundee refused to re-house those displaced by the clearing of Greenmarket and Overgate.

¹⁶⁶ Begg, *op. cit.*, p. 16.

¹⁶⁷ Rent control was first partially removed in 1957.

In July 1917 a committee was established jointly by the President of the Board of Trade and the Secretary for Scotland, to advise on the building of houses for the working classes after the war. This committee laid down levels of construction and design that continued to be regarded as permanent standards throughout the 1930s. From 1917 the Reconstruction Ministry in Lloyd George's government also addressed the problems of working class housing. It was agreed that, after the war, a housing drive should be organised and funded by the state. While the Ministry favoured direct action by central government, the Treasury view was that local authorities should be responsible, supported only by such financial aid from Treasury funds as proved necessary. The Treasury view prevailed and the building of working class housing of a national standard became the responsibility of local government. The Royal Commission on the Housing of the Industrial Population of Scotland, Rural and Urban in 1917 showed how much had to be done. Not only were there too few houses, much of the housing stock was of very poor quality and of inadequate size. As the 1911 census had already shown, 53.2% of Scotland's houses were of only one or two rooms.

The House and Town Planning (Scotland) Act of 1919 (the Addison Act) required local authorities to review their housing stock and to submit to the Ministry of Health plans for the provision of the required number of houses for the working class. In addition to borrowing, local authorities were given permission to raise rates by four fifths of a penny. The difference between the income from that token contribution from the rates together with the expected income from rents and the cost of borrowing was to be borne by the Treasury.

Progress was slow. Local authorities were unprepared for their new responsibilities. There was a shortage of building materials. By 1921 the financial climate had changed for the worse. The Chancellor feared that as the Addison scheme speeded up the cost would become unsupportable. The scheme was abandoned; in Scotland only 25,129 houses had been built. In 1923 the Chancellor in the Conservative government attempted to shift the responsibility back to the private

sector, with the state providing a subsidy of £6 for each house built. While in England and Wales these subsidies led to the building of 438,000 houses, in Scotland there was no such response and public sector house completions in 1924 and 1925 fell back to the lowest levels of the inter-war years.

The breakthrough for housing in Scotland was the Housing (Financial Provisions) Act of 1924 (Wheatley Act). Local authorities received a subsidy of £9 per house (£12 10s in rural areas) for forty years. Rents were to be set in line with average rents for similar houses but could be raised to cover costs in excess of the rate contribution of £4 10s per house. The provisions of the Wheatley Act were retained by the Conservative Government elected in 1925. Local building increased steadily over the following years and by 1933 over 100,000 council houses had been built in Scotland.

Following the economic crisis and the collapse of the Labour government the Wheatley Act was repealed in 1933. It was replaced by the Housing Act of 1933 that again concentrated all effort on the clearing and the replacement of slums. This Act did not work well in England where there was disagreement about the definition of a slum. In Scotland there were easily recognisable slums in abundance. There was no slackening of the pace of building even after the withdrawal of the Wheatley Act; in 1935 a record number of 18,814 council houses were completed in Scotland.

It was following these efforts that Cathcart was 'gratified to record'¹⁶⁸ that almost all local authorities in Scotland had fully accepted their responsibilities. Between 1919 and 1935 over 200,000 new houses had been built for the working classes in Scotland under state-aided schemes. Despite this achievement, the Committee acknowledged that overcrowding remained a serious problem and that there were still many slums to be cleared although 'the numbers of new houses required will not be known with anything approaching precision until the surveys that are now being carried out under the recent Housing Act¹⁶⁹ are completed.'¹⁷⁰ Already,

¹⁶⁸ Cathcart Report, p. 142.

¹⁶⁹ Housing (Scotland) Act, 1935.

in addition to the inadequate numbers of houses, it was known that in Scotland there were over 300,000 houses with water-closets common to two or more houses, some 30,000 without any water closet and many without running water.¹⁷¹ Nevertheless the Cathcart Committee was confident that 'the housing programmes that are now under way throughout the country are raising the standard of living of a large part of the population.'¹⁷²

Again the Cathcart Committee was being circumspect. Overcrowding in Scotland was still severe. While Census figures showed that between 1881 and 1931 that the average number of persons per house had fallen from 5.06 to 4.08 and the number of persons per room had fallen from 1.59 to 1.27 this could be attributed, in large part to the falling birth rate and the reduction in family size. Even if this trend continued it would only have a marginal effect on the problem. There was still a serious absolute shortage of houses, not only of suitable size but also of suitable standard. Under Section 5 of the Housing (Scotland) Act, 1925 local authorities had been required to inspect the houses in their areas and report their findings. Local authorities were slow to respond¹⁷³ but gradually the picture began to emerge and from 1929 was reflected in the *Annual Reports of the Department of Health for Scotland*. It soon became clear that the housing problem did not exist only in the towns and cities. In the rural areas up to 75% of the working-class houses were considered to be unfit for human habitation.¹⁷⁴

In 1936 investigations, continued by local authorities under the Housing (Scotland) Act, 1935, provided the Department of Health with the overall figures for Scotland.¹⁷⁵ These showed that 259,194 houses had been built in Scotland since 1919. Of these only 44,081¹⁷⁶ had been built privately; 83% had been built under state

¹⁷⁰ Cathcart Report, p. 143.

¹⁷¹ Ibid., p.124.

¹⁷² Ibid., p. 146.

¹⁷³ *Hansard*, cccxxiv, HC 24 June 1937, col. 1462.

¹⁷⁴ Ibid., col. 1463.

¹⁷⁵ *Annual Report of the Department of Health for Scotland*, 1936, Cmd. 5407.

¹⁷⁶ This figure only includes houses of five rooms or less.

aided schemes. However, although a record number of contracts were approved for 1936, the number of houses actually completed was falling because of a general shortage of building workers, particularly bricklayers.

The Department of Health report in 1936 improved on the information on overcrowding given by the Census of 1931 by taking into account size as well as number of rooms and the scope for the separation of the sexes. The extent of overcrowding was confirmed; the average percentage of overcrowded houses in Scotland was found to be 22.6% compared with 3.8% in England. The worst overcrowding was found to be, not in the cities, but in the industrial towns in the west of Scotland- Clydebank 44.9%, Coatbridge 44.8%, Port Glasgow 42.1%, Motherwell 40.5%. The situation was almost as bad in the mining areas where there was no evidence of improvement since the Royal Commission on Housing reported in 1917 – in Fife (Cowdenbeath 39.9%, Lochgelly 35%) in landward Lanarkshire 36.9% and landward West Lothian 34.1%.

In these industrial towns and mining communities the population was overwhelmingly working class. While a very large proportion of the overcrowded houses of Scotland was in the large cities, their number there was diluted to an extent by the houses of the more prosperous. The percentage of overcrowded houses was therefore lower although still dreadful - Glasgow 29.1, Dundee 23.9, Aberdeen 22.1 and Edinburgh 17.2. Of comparable cities in England only Sunderland (20.6) had overcrowding of this degree. In other great cities in England – eg. Liverpool (7.4), Bristol (2.1) and Plymouth (6) - overcrowding was on a different scale.

In 1936 it was estimated¹⁷⁷ that 161,749 additional houses would be required to put an end to overcrowding. Unfortunately the situation was complicated by the process of slum clearance. From 1931, 51,736 houses had already been demolished or closed, displacing 241,243 people who had to be re-housed. The inspection of houses by the Department of Health for Scotland continued. 'The reports both of the

¹⁷⁷ *Annual Report of the Department of Health for Scotland, 1936*, Cmd. 5407, p. 22.

independent commissioners appointed by the Department and of the Department's own inspectors continue to disclose housing conditions which are almost beyond belief.¹⁷⁸ It was therefore clear that the suggested requirement of 161,749 additional houses would prove to be an under-estimate.

The Department of Health gave an even more stark account of the overcrowding and bad housing in Scotland than that revealed in the Cathcart Report. However the Report did show that the housing problem had an adverse effect on the health of the people. The evidence cited related to deaths from measles and tuberculosis, childhood deaths, and general death rates. A study of deaths from measles showed that such deaths in Glasgow, where 55% of houses were of one or two rooms, were three times higher than in Birmingham where only 4% of houses were of those sizes. Again using Glasgow statistics a study in 1932 showed a clear association between the number of apartments and both the case rate and the death rate from tuberculosis. Such relationships between the number of rooms and the death rates of children under five and general death rates had already been shown in studies by Dr. A.K. Chalmers in 1911. By 1936 such relationships were no longer controversial and it was generally accepted that the re-housing of slum dwellers would inevitably improve their health.

However, in the 1930s there was a new subject of controversy. 'It has been suggested in some quarters that tenants transferred from slum areas to re-housing schemes have to forego necessary food in order to pay the higher rents.'¹⁷⁹ Cathcart accepted that this would be serious if it were true. However the Committee was 'of the opinion that there is no first hand data to justify a definite conclusion on this point.'¹⁸⁰ However in England where the housing problem was less extreme the inability of re-housed tenants to pay for an adequate diet had been described in the early 1930s by McGonigle and Kirby and in their *Poverty and Public Health* in

¹⁷⁸ Ibid., p. 24.

¹⁷⁹ Ibid., p.146.

¹⁸⁰ Ibid.

1936.¹⁸¹ In Scotland this was a matter of even greater concern; in 1935 it was discussed at the General Assembly of the Church of Scotland as ‘the most important problem of all’¹⁸² in the slum clearance districts.

The people have been compulsorily removed from their old environments into houses where rents are higher than those to which they are accustomed. It is no longer possible for them to live on the few shillings on which formerly they were able to make ends meet. Many, even of the most careful, become involved in debt, and with debt comes discouragement. The size of the slum clearance house, too, presents its own difficulties. Many of the families arrive at their new homes pushing all their worldly goods in front of them in a wheelbarrow. They cannot afford to furnish the extra rooms with which they have been provided, but these empty rooms mean constant calls from hire-purchase canvassers and it is difficult to refuse the “easy” terms which they offer. Soon, for many, the burden of debt is overwhelming.¹⁸³

The Cathcart Committee was fully aware of the importance of housing for the future of the health of the people of Scotland. However the Committee did not reveal the true severity of the deficiencies in the 1930s and the extent of the difficulties to be overcome. The Committee’s confidence in the legislation as it existed in 1936 now seems to have been misplaced.

Conclusion

The Cathcart Report was the first statement of policy for health in Britain in the twentieth century to give first place to improvement in the environment. In the condition of the 1930s this priority was fully justified and the Cathcart Committee was not blind to the gross deficiencies and disorganisation in the local authority environmental services as they were at that time. However, in line with the practice followed throughout its Report, the Cathcart Committee avoided unnecessary, and

¹⁸¹ G.M.C. McGonigle and J. Kirby, *Poverty and Public Health* (London, 1936).

¹⁸² *Minutes of the General Assembly of the Church of Scotland*, 1935, p 389.

¹⁸³ *Ibid.*

possibly counterproductive, confrontation with those whose co-operation would be required in the creation of a new and reformed health service. Although the local authorities had clearly failed to maintain services at an acceptable standard the Cathcart Committee was at pains to point out that it was a witness representing the local authorities who had 'urged strongly the need for a revised and consolidated sanitary code' and that the Cathcart Committee had 'no hesitation in endorsing this view.'¹⁸⁴ The tactic succeeded in that a useful consensus was maintained and improvements were achieved before the Second World War. In retrospect however it can be seen that the Cathcart Committee allowed the problems in Scotland to be understated in the major survey of environmental conditions before the creation of the NHS. As a result plans for improvement of the environment were not sufficiently geared to the problems of Scotland as distinct from those of the United Kingdom as a whole.

¹⁸⁴ Cathcart Report, p. 142.

CHAPTER SIX

THE STATE MEDICAL SERVICES

The Cathcart Committee found that the state medical services, as they were in 1936, had not come together to form a coherent organisation¹ or to embody any coherent national health policy. In its determination to maintain the co-operation and good will of all those who would be essential to future health services, the Committee was careful not to include in its Report the substantial evidence that divided, inadequately resourced and very unevenly implemented as they were, the existing medical services had failed to achieve the objectives for which they had been set up.

The Committee was to propose a health policy that, although designed in Scotland, would have to be acceptable in Britain. The Committee had to keep in mind the differences between the health services in Scotland and in England and Wales determined by their very different histories. The differences were very clear to the Cathcart Committee in the preparation of its Report and still had to be taken into account in planning the NHS. The differences were particularly significant in relation to the services under the Poor Law.

The Poor Law Medical Service

Historical Background

The medical service established in 1845 under the Poor Law gave Scotland its first rudimentary national medical service and its first central body with a national responsibility for health care. The Poor Law (Amendment) Act of 1845 was the result of a movement to make provision for the poor a matter of central responsibility as it was already the case in England.

¹ Cathcart Report, p. 26.

The English Act of 1834² was largely the products of Utilitarian ideas Edwin Chadwick. Its primary purpose was to contain the growing cost of pauperism. Chadwick recognised in disease a major cause of poverty, and convinced of the theory that the main source of disease was miasma and believed that pauperism could be diminished by its removal by improved sanitation.

Chadwick's Act did not provide for the medical care of those who had become poor, whether or not their poverty was due to sickness.³ However the 1834 Act allowed for the appointment of 'officers' providing a loophole which made it possible for Boards of Guardians to take the initiative to employ 'medical officers.'⁴ Many were recruited but appointments were entirely at the discretion of the Guardians and their selection of candidates was arbitrary and haphazard and the medical officers often unlicensed.

In 1842 the Poor Law Commissioners issued a General Medical Order establishing an official medical service under the Poor Law to be staffed by medical officers holding licences to practice in England. However many of the medical officers employed in the new service, although licensed, were still virtually untrained and barely literate.⁵ Nevertheless, Chadwick came to accept that the rudimentary medical service that had come about so unexpectedly as a by-product of his 1834 Act was useful at the level of his own very limited requirements. Chadwick regarded doctors as 'necessary evils not likely to last' since they would ultimately become redundant⁶ as a result of his projected sanitary improvements.

² Poor Law (Amendment) Act, 1834.

³ R. Hodgekinson, *The Origins of the National Health Service* (London, 1967), p. 3.

⁴ *Ibid.*, p. 335.

⁵ F. N. L. Poynter, *The Evolution of Medical Education in Britain* (London, 1966), p. 198.

⁶ Hodgkinson, *op. cit.*, p. 639.

In Scotland different ideas prevailed. In Scotland it was an accepted principle that relief should not be extended to the able-bodied poor.⁷ Nor was there support for Chadwick's theory that miasma was the dominant cause of the diseases of the poor. In their teaching W. P. Alison in Edinburgh⁸ and Robert Cowan in Glasgow,⁹ emphasised the importance of poverty in undermining the health of a large section of the people of Scotland. They stressed particularly that unemployment and the consequent privation and mental depression, were more important in laying the poor open to endemic and epidemic fevers than 'any cause external to the body itself.'¹⁰ They pointed to 'the amount of poverty and subsequent suffering as the main cause of the great mortality in Edinburgh and Glasgow.'¹¹ In 1840 Alison in his *Observations on the Management of the Poor in Scotland and its Effect on the Health of the Great Towns* set out his evidence that the excessive mortality in Scotland was caused by the 'grand evil of Poverty'¹² and refuted all the contemporary objections to enacting Poor Laws for Scotland along the lines of those already in force in England.

Even before this publication, the Royal College of Physicians of Edinburgh had resolved to take action on behalf of the urban poor.¹³ On 4 February 1840 the College had petitioned the Queen, 'praying that the Enquiry of the Poor Law

⁷ It has been said that it was 'the principle of the Scotch Poor Law to under-supply the paupers and to let them get the rest of what they want from their neighbours.' R. Mitchison, *The Old Poor Law in Scotland* (Edinburgh, 2000), p. 192. Almost nothing was spent on medical aid even for those on the parish roles of paupers. I. Levitt and C. Smout, *The State of the Scottish Working Class in 1843* (Edinburgh, 1979,) p. 217 and p. 228.

⁸ W. P. Alison was Professor of Medicine at Edinburgh University and President of the Royal College of Physicians of Edinburgh.

⁹ Professor of Medical Jurisprudence and Police at Glasgow University

¹⁰ W. P. Alison, *Observations on the Management of the Poor in Scotland and its Effect on the Health of the Great Towns*, (Edinburgh, 1840), p. 21.

¹¹ *Ibid.*, p.ix.

¹² *Ibid.*

¹³ *Minutes of the Royal College of Physicians of Edinburgh*, 4 February 1840.

Commissioners may be extended to Scotland,'¹⁴ referring to the inquiries then being made by Commissioners into the sanitary condition of the labouring classes in England and Wales. Within a very few days, on the 19 February, the Home Secretary replied indicating that the Commissioners 'had undertaken to extend their labours to Scotland.'¹⁵

In his *Remarks on the Report of Her Majesty's Commissioners on the Poor Laws of Scotland presented to Parliament in 1844*,¹⁶ Alison gave general approval to the work of the Commission in Scotland but deplored the lack of any proposal to provide aid for the poor unemployed. He also regretted that it was not proposed to build more large workhouses in which hospital wards could be included. Scotland had only four such workhouses, three in Edinburgh and one in Paisley.

The Poor Law (Scotland) Amendment Bill was drawn up as recommended by the Commissioners and passed in 1845.¹⁷ Alison and the Royal College of Physicians had hoped for more effective central control by the state but the Bill had allowed the new Board of Supervision in Edinburgh so little authority that local administration was left 'subject only to the power of public opinion.'¹⁸ The Board had been created only as an advisory body with powers to act as a court of appeal in cases of dispute within parishes and it had been given no powers of direction.¹⁹ Effective power was given to Parochial Boards and, crucially, still no support was to be given to the able

¹⁴ Ibid.

¹⁵ Ibid., 5 May 1840.

¹⁶ W. P. Alison, *Remarks on the Report of Her Majesties Commissioners on the Poor Laws of Scotland Presented to Parliament in 1844* (Edinburgh, 1844).

¹⁷ R. A. Cave, *The Scottish Poor Law 1745-1845* (Edinburgh, 1981), p. 140.

¹⁸ Alison, op. cit., p.vi.

¹⁹ Technically the Board was a sub-department of the Home Office. The Chairman was Sir John McNeil, a Tory, but the Board was not intended to act as an instrument of the Home Office but rather to reflect opinion in Scotland. Three Sheriffs (Ross, Perth and Renfrew) represented the counties. The Lord Provosts of Edinburgh and Glasgow represented the towns. The Scottish legal system was represented by the Solicitor-General. There were two further Crown appointments; McNeil insisted that one should be a Whig. I. Levitt, *Government and Social Conditions in Scotland 1845-1919* (Edinburgh, 1988).

bodied unemployed. Relief was confined to the aged and the infirm. The Parochial Boards were empowered to impose 'assessments' only as they thought fit and assessment for the support of the poor was not made obligatory. Still dominated by the precepts of the Church,²⁰ only 230 of Scotland's 840 parishes opted to raise rates for the relief of the poor in 1845. For decades thereafter most Parochial Boards continued to rely on the 'free-will' offerings of their congregations. The ability of the Church to care for the poor was further weakened by the Disruption. In the great majority of parishes funds had never been enough to give adequate support to their poor; now each parish of the divided church drew on its limited resources only for the support of members of their own persuasion.

However, unlike the equivalent Act for England and Wales, the Poor Law (Scotland) Amendment Act of 1845 had placed a statutory obligation on Parochial Boards in each parish to provide medical attendance and medicines for the poor.²¹ A rudimentary medical service began to emerge in Scotland and in 1848 the Board of Supervision attempted to strengthen it. A grant of £10,000 from Treasury funds enabled the Board to subsidise any parish that agreed to make a formal appointment of a salaried Medical Officer.²² There was no shortage of applicants from among Scotland's many medical graduates.²³ Nevertheless the system soon proved to be unsatisfactory. In rural areas, even in the largest parishes, the number of parishioners able to contribute to parish funds was often too small to provide even the finance that would have attracted a grant from central funds. In the rapidly growing industrial centres the problem was overwhelming. The old parish structure could not support the vastly increasing numbers of their new poor.²⁴ The hospital accommodation that

²⁰ M. A. Crowther, 'Poverty, Health and Welfare,' in A. H. Fraser and R. J. Morris, *People and Society in Scotland* ii (Edinburgh, 1990), p. 266.

²¹ Sir George Nicholls, *A History of the Scotch Poor Law* (London, 1856), p. 179.

²² *Ibid.*, p. 214.

²³ *Ibid.*, p. 262. 7,989 doctors had graduated from Scottish Universities between 1801 and 1850.

²⁴ Thomas Chalmer's parish, St John's in Glasgow, was an outstanding exception. S. J. Brown, *Thomas Chalmers and the Godly Commonwealth* (Oxford, 1982), p. 153; Cave, *op.cit.*, p. 143.

Alison had called for did not materialise. While in England the large Unions could afford to build workhouses with wards for the care of the sick, in Scotland there were no Unions, individual parishes proved unwilling to join forces to build large poorhouses and only in very exceptional circumstances could individual parishes build poorhouses with hospital accommodation.²⁵

After 1845 the number of the registered poor continued to increase to reach a new record level in 1868 when 41 per thousand of the population were entitled to relief under the Poor Law. Of this large number 6.7% were now lodged in Scotland's poorhouses²⁶ and parochial councils had become more liberal in the interpretation of 'destitute' and 'able-bodied.' A group of Liberal MPs complained about the rising cost of the Scottish Poor Law, suggesting that, without political accountability, the Board of Supervisors and the parochial boards had become too generous. However a Select Committee found that the rising cost had to be attributed to factors outside the Board's control. No changes were made in the administration of the Poor Law and the powers of the Board of Supervisors to contain costs were not increased. Faced with ever rising costs, more and more parochial boards found themselves forced to opt to impose assessments on their parishes.²⁷

In the later part of the century the proportion of the population recognised as paupers declined from the peak of 1868; small poorhouses were built and the proportion of the poor receiving in-door relief increased. In 1894 the responsibilities of the Board of Supervisors were taken over by a Local Government Board. Parochial Boards were replaced by elected parish councils to be responsible for both the

²⁵ In 1865 the St Cuthbert's Parochial Board in Edinburgh was able to sell its poorhouse in Lothian Road to the Caledonian Railway Company which required the site for its Edinburgh terminal. The sale price of £115,000 allowed the parochial Board to build a new poorhouse to a high standard at Craigleith. In Glasgow in 1889 the City and Barony parishes took the most unusual decision to combine forces; the site of the old City Poorhouse was sold to the railway company providing funds sufficient to build small hospitals at Duke Street and Oakbank and a hospital for the chronic sick at Stobhill.

²⁶ *Annual Report of the Scottish Board of Health*, 1920, Cmd. 1319, p. 224.

²⁷ All Scotland's parishes were eventually assessed by 1909.

administration of the Poor Law and the Public Health. In this new organisation of responsibilities the administration of the Poor Law remained much as before. The proportion of the population entitled to medical relief remained almost constant at approximately 22 per thousand for some years.

Poor Law Services in the 1930s

Real change began only with the introduction of Old Age pensions in 1908. The number on the Poor Roll aged over 70 years fell from 15,389 to 5,469 in 1910. A few years later, during the First World War there was a further dramatic fall in the proportion of the population on the Poor Roll and many poorhouses were made over to the armed forces. In 1919 the new Board of Health for Scotland found that the number of poor accommodated in poorhouses was little more than half what it had been before the war. Of the poorhouses now being returned by the armed forces, several were renovated to provide accommodation for infectious disease, mental deficiency or convalescence and others were sold off. From a total of 65 at the turn of the century, there were only 18 in 1919. In the more optimistic and more enlightened climate of the years immediately after the war it became usual to drop the name 'poorhouse' in favour of 'hospital' or simply 'house'. Sir George McCrae, the Chairman of the new Board of Health also took a liberal line on outdoor support for the unemployed, urging parochial councils to 'adopt a broad view.'²⁸

But after 1920 rising unemployment quelled the optimism and the miners' strike in 1921 created a crisis. The case for providing for the able-bodied unemployed, first advocated by Alison in 1840, now became overwhelming and was at last officially accepted in the Poor Law Emergency Provision (Scotland) Act of 1921.²⁹ The *Annual Reports of the Scottish Board of Health* show that in 1921 outdoor aid was given to 1,478 able-bodied unemployed and their dependants. By 1922 that

²⁸ I. Levitt, *Government and Social Conditions in Scotland 1845-1919*, op.cit., p. 106.

²⁹ The provisions for the unemployed in this Act were renewed annually by Expiring Laws Continuation Acts until established by the Poor Law (Scotland) Act of 1934.

number had risen dramatically to 147,420, outnumbering the 100,981 officially recognised 'ordinary poor.' Thereafter the proportion of the population on the Poor Roll continued to rise. In 1930 one of the effects of the Unemployed Insurance Act was to reduce the number of able-bodied unemployed recorded on the Roll by almost a half;³⁰ after 1932 lunatics and mental defectives (at that time 4.1 per thousand of the population) were also excluded from the Poor Law statistics.³¹ In spite of this statistical redistribution of those in need of relief, the proportion of the population recorded as being entitled to Poor Law relief reached 82 per thousand in 1934.³²

By then the Local Government (Scotland) Act of 1929 had transferred the poor law functions of parish councils to county councils and the town councils of large burghs. In the judgement of the new Department of Health for Scotland the old parish councils had made valiant efforts to meet the needs of the poor but had been 'armed with a defective instrument'.³³ The Department believed that, in its turn, the 'machine' that it had inherited was still defective.³⁴ While the numbers in need of support were increasing, and problems were being made worse by a new wave of ill health, the resources and organisation of the Poor Law medical services were clearly inadequate. Medical care was provided but at a very low standard. There was an acute shortage of hospital accommodation. All institutions were overcrowded and 'it was not uncommon to find in one institution the acutely sick, the chronic invalid, the senile poor, young children, able bodied, vagrants, mental defectives and lunatics.'³⁵ Since no proper medical records were kept the effectiveness or otherwise of their medical care could only be guessed at.

Under the new administration after 1929, in which counties and large burghs replaced parish councils as the relevant local authorities, poor law expenditure was spread over wider areas and larger numbers of ratepayers removing some of the

³⁰ *Annual Report of the Department of Health for Scotland*, 1930, Cmd. 3860, p.161.

³¹ *Ibid.*, 1932, Cmd. 4338, p.130.

³² *Ibid.*, 1934, Cmd. 4837, p.135.

³³ *Ibid.*, 1930, Cmd. 3860, p.155.

³⁴ *Ibid.*

³⁵ *Ibid.*, 1929, Cmd. 3529, p.167.

glaring inequities that had existed between parishes. Within the administration of the new authorities responsibility for health care was separated from the ordinary maintenance of the poor and had come under the administration of the public health committees (although still chargeable to the Poor Law). The Department hoped that local authorities would take advantage of Section 27 of the Local Government Act to provide general hospitals that would then be available to the paupers as well as the general public.³⁶ The burden of the Poor Law medical service was further reduced by transferring its services for mothers and children under five, for children of school age, for the blind, and for the mentally deficient to the appropriate municipal services. By concentrating on the remaining, largely indoor, services it was hoped that medical care for the poor could be improved even within the financial restrictions of the rating system.

However by 1935 the looked-for improvements had not taken place. A Departmental Committee was set up under the Chairmanship of James Keith K.C:

To examine the existing statutory provisions relating to the relief of the poor in Scotland and to make recommendations as to which of such provisions should be re-enacted in a consolidating measure and which of such provisions should be repealed as having become obsolete; to consider how far it is desirable that matters relating to the relief of the poor which are at present governed by common law and practice should be made the subject of statutory enactment and to make recommendations with regard thereto; to review the law of settlement and recourse and make recommendations with a view to its simplification or abolition.³⁷

It fell to the Cathcart Committee rather than to Keith to provide the Department of Health with the required guidance on the care of the poor, specifically on the 'question of policy and organisation in the treatment of sickness.'³⁸

The conclusions of the Cathcart Committee were damning:

³⁶ Ibid., 1930, Cmd. 3860, p. 158.

³⁷ Ibid., 1935, Cmd. 5123, p. 148.

³⁸ Ibid., p.1.

The poor law medical service is generally regarded as unsatisfactory, and efforts at improvement cannot overcome the difficulties inherent in the maintenance of a separate service for persons only when they are destitute. The legislature has already recognised that a separate hospital service for the sick poor is undesirable; a separate domiciliary medical service for the sick poor is no less undesirable.³⁹

Cathcart recommended that domiciliary medical treatment should no longer be provided under the Poor Law. Local authorities should be empowered to provide medical attendance for those who could not afford the services of a general practitioner but with the right of recovery of fees from those who could afford to make a contribution. This service should also ensure that, as far as possible, the continuity of care by a family's normal doctor would not be interrupted during periods of poverty.

At the same time local authorities were urged not to launch new services which might be at variance with the general health policy to be set out in due course in the Cathcart Committee's Report. The Committee also hoped that a Departmental Committee, which had already been appointed, would recommend that, where necessary, medical treatment should be available to all without any distinction between the general public and the poor.⁴⁰

Other Local Authority Medical Services

The local authority medical services operating in the first half of the twentieth century were extensions of the organisations set up under the public health legislation in the previous century. The publication of Chadwick's *Report on the Sanitary Conditions of the Labouring Populations of Great Britain* in 1842 was followed in 1846 by the Health of Towns Act and the Town Improvement Act both for England and Wales. The 1842 report had included *Local Reports Relating to Scotland*; by 1847 a Public

³⁹ Cathcart Report, p. 214.

⁴⁰ Ibid.

Health (Scotland) Bill and a Police of Towns (Scotland) Bill were in draft form. In Edinburgh a committee set up by the Royal College of Physicians was enthusiastic about the impending legislation since 'measures are even more demanded by the present sanitary condition of the towns of Scotland than those of England.'⁴¹ It was agreed that the English Acts of 1846 formed an excellent model that could be adapted for Scotland.

While the Scottish legislation was still in preparation the great Public Health Act of 1848 was passed, aimed principally at improving conditions outside London. At that time Scotland had been forewarned of an epidemic of cholera.⁴² In Edinburgh the customary meeting⁴³ was convened to make the appropriate preparations. It was then discovered that, by the very recent Public Health Act, responsibility for the control of epidemics had passed to the new General Board of Health; this Board, it emerged, had no powers of delegation to any local organisation. In the confusion the Committee in Edinburgh decided to make its own arrangements, only keeping the General Board informed.

It was this experience that made the Public Health (Scotland) Bill so welcome to the special committee of the Royal College of Physicians. The Bill brought together the provisions of the various Police Acts across Scotland. The College particularly welcomed the provision in the Bill for the appointment of Medical Officers of Health. On the other hand, the arrangements proposed for the election of Local Health Boards were thought to be unworkable in Scotland,⁴⁴ and even more objectionable was the proposal that the General Health Board in London should have overall administrative control in every part of the Great Britain.⁴⁵ A counter proposal was made that, for

⁴¹ *Minutes of the Royal College of Physicians of Edinburgh*, 14 May 1847.

⁴² H.P. Tait, *A Doctor and Two Policemen: The History of the Edinburgh Health Department* (Edinburgh, 1974), p. 16.

⁴³ Representatives of the Town Council, the Parochial Councils, the Royal College of Physicians of Edinburgh and the Royal College of Surgeons of Edinburgh.

⁴⁴ *Minutes of the Royal College of Physicians of Edinburgh*, 1 May 1848.

⁴⁵ There seems to be little evidence to support the assertion by some historians (e.g. Sir John Brotherston in 'Scottish Health Services in the Nineteenth Century,' in G. McLachlan (ed.) *Improving the Common Weal* (Edinburgh, 1987), p. 12.) that

Scotland, the central administrative body should be the existing Board of Supervision (extended by the appointment of medical members and an additional secretary) and that the existing Police Committees should act as the Local Health Boards.

A petition proposing these amendments was sent to the Lord Advocate for presentation to Parliament. The amendments were not accepted and the Public Health (Scotland) Bill was withdrawn.⁴⁶ A second petition in 1850 called for amendments in the remaining Scottish Bill, now the Police and Improvement Bill. When this Act became law in 1851, the Royal College of Physicians of Edinburgh was satisfied that it had 'succeeded in getting almost all we wished into the Police and Improvement Bill.'⁴⁷ But in fact this was a weak adoptive Act that only allowed Sheriffs limited powers for the improvement and maintenance of streets and other public places and some control of town planning. Public health measures for Scotland continued to be fragmented, determined by local Police Acts. Most importantly, the power to appoint medical officers of health, made possible by the English legislation, had been lost for Scotland by the withdrawal of the Public Health (Scotland) Bill.

Calls for the appointment of medical officers of health in Scotland continued. In Edinburgh the issue was discussed by the Lord Provost's Committee on a number of occasions.⁴⁸ However the Committee was uncertain about the duties of such an office and doubted the Council's power to make such an appointment. On 24 November 1861 there was a violent public agitation following the collapse of a tenement at 99-103 High Street.⁴⁹ A great public meeting elected a deputation to urge on the Council the need for a medical officer of health but the Council was still reluctant. A second deputation of the President of the College of Physicians, the President of the College of Surgeons and the most eminent medical men of the time, Sir James Young Simpson, James Syme and Sir Robert Christison was allowed to

differences on the importance of miasma was the main cause of objection to the proposed legislation for Scotland.

⁴⁶ *Minutes of the Royal College of Physicians of Edinburgh*, 1 May 1848

⁴⁷ Minute of the Royal College of Physicians of Edinburgh, 3 February 1852.

⁴⁸ Tait, *op.cit.*, p. 17.

⁴⁹ *Ibid.*

attend a meeting of the Town Council⁵⁰ on 30 September 1862. On the uncertain basis of a Police and Improvement Act of August 1862, the Council agreed to appoint a Medical Officer of Health but only by a single vote, 17 to 16. Henry Littlejohn was appointed. In 1863 a local Police Act allowed the appointment of William Gairdner in Glasgow. Other towns followed and in 1867 the appointment of Medical Officers in all burghs became obligatory under the Public Health Act.

The initial appointments proved to be productive and the first generation of Medical Officers of Health and their successors won the active support of the Committees (later the Public Health Committees)⁵¹ to which they were answerable. It was this combination of reforming Medical Officers of Health and their supportive Public Health Committees that developed the municipal services that served a large section of the Scottish population until the establishment of the NHS. Under a succession of outstanding Medical Officers of Health – William Gairdner, J.B. Russell, A.K. Chalmers, and Sir Alexander McGregor – Glasgow showed how far these services could be developed.⁵²

Infectious Diseases

Until the first half of the nineteenth century Scotland had no permanent system for the management of infectious disease. At the approach of epidemics, in the larger towns at least, special temporary arrangements were made. Shelters were set up in small hospitals for the reception of those who could not be managed at home. Houses of quarantine were designated as places of refuge for the healthy. Dispensaries were established to issue medicines and a list of doctors willing to give their services was drawn up. As each crisis passed these arrangements were abandoned.

⁵⁰ In Edinburgh the Police Commissioners and the Town Council had merged. This did not happen in other Scottish Towns until 1900.

⁵¹ The appointment of Public Health Committees followed the Public Health (Scotland) Act of 1867 but in many cases they were not inaugurated for some years. J. A. Gray, *Edinburgh City Hospital* (East Linton, 1999), p. 30.

⁵² A. Macgregor, *Public Health in Glasgow* (Edinburgh, 1967).

Lister's success with antiseptic surgery in Glasgow, and later in Edinburgh, and the work of Pasteur in France inspired a new interest in the possibility of controlling infectious disease. An essential first step was the notification of infections. It was first suggested (in Greenock in 1877) that the patient should be responsible for notifying his own illness. After much persuasion by Henry Littlejohn, as Medical Officer of Health, the Edinburgh Municipal and Police Act of 1879 made notification obligatory and placed the obligation on the diagnosing doctor.⁵³ This was the first program for the notification of infectious disease in the United Kingdom. The example was gradually followed elsewhere and became compulsory in Scotland in 1889.

By then the arrangements for the care of patients with 'fevers' had changed radically. In Glasgow during a typhus epidemic in 1864-5 the Poor Law authorities gave notice that they would no longer admit 'fever' patients other than paupers to hospital accommodation under their control.⁵⁴ William Gairdner, the Medical Officer of Health, then successfully argued for the establishment of a permanent fever hospital. Scotland's first fever hospital was opened at Parliamentary Road in 1865.⁵⁵ In 1866 when a cholera epidemic threatened in Edinburgh, the Royal Infirmary gave notice that it would not admit infectious cases to its small unit for 'fevers'.⁵⁶ The Medical Officer of Health, Henry Littlejohn persuaded the Corporation to set aside part of the City Poorhouse Hospital for these patients; this proved inadequate and the Corporation finally agreed to buy the Canongate's Poor House which was then converted to become the first of Edinburgh's succession of City Hospitals for infectious disease.⁵⁷ These examples were followed elsewhere across Scotland and in 1897 the Public Health (Scotland) Act required all local authorities to provide infectious disease hospitals. The number of hospitals increased rapidly according to a

⁵³ Tait, op.cit., p. 29.

⁵⁴ A. K. Chalmers, *The Health of Glasgow 1818-1925* (Glasgow, 1930), p. 277.

⁵⁵ Ibid., p. 151.

⁵⁶ Tait, op.cit., p. 31.

⁵⁷ Gray, op.cit., p. 48.

formula that recommended one bed for every 1000 of the population in urban areas and one bed per 1500 in rural areas.

In 1929, when the Department of Health for Scotland became the responsible authority, it found that there were 179 hospitals and 18,670 beds almost entirely for the treatment of infectious disease. By then, as a result of the improvement in social conditions and the success of immunisation schemes, the incidence of infectious disease had declined. The freed space was often taken up for the treatment of pneumonia and other non-notifiable diseases. There was also an increasing expectation that infectious disease hospitals should become centres for treatment rather than for isolation. In the large city hospitals, with appropriate accommodation and adequate medical staff, this new role could be fulfilled. But most Scottish 'fever' hospitals remained, as they had been for many years, small with poorly trained nursing staff and with medical direction in the hands of the local Medical Officer of Health as a part time responsibility.⁵⁸

The Society of Medical Officers in Scotland, in its evidence to the Cathcart Committee, stated that hospitals for infectious disease should 'be at least large enough to employ a full-time resident medical officer and to be recognised as a training school for nurses.'⁵⁹ They also reported:

The great majority of existing hospitals were constructed to accommodate only a few diseases, usually in fairly large wards. There is general agreement with the modern view that a high proportion of the total accommodation should be in the form of cubicles or small wards of from four to six beds. Such an allocation would provide not only for a large variety of diseases, but also for the observation and treatment of obscure and special cases, which in most hospitals constitute a real problem.⁶⁰

⁵⁸ T. S. Wilson, 'The Public Health Services,' in G. McLachlan, *Improving the Common Weal* (Edinburgh, 1987), p. 229

⁵⁹ Cathcart Report, p. 196.

⁶⁰ Ibid.

Cathcart concluded that while infectious disease services was generally passively accepted by the public, local authorities were hampered in the development of a service up to modern standards, not only by the lack of modern hospital accommodation but by the inadequacy of medical and nursing care at home. It was hoped that the extension of the general practitioner service, proposed in another part of the Report, would ensure earlier diagnosis and allow effective treatment at home. Local authorities would then be able 'to utilise their hospital facilities to the best advantage.'⁶¹ It was also recommended that infectious disease hospitals should no longer be seen as places for isolation but as centres for modern treatment. For this purpose the existing small hospitals were clearly unsuitable and uneconomical. It was recommended that in future treatment should be in units large enough to provide modern specialised facilities and accommodation, not in large general wards, but in cubicles, or small wards dedicated to the treatment of particular diseases.

The Cathcart Committee's recommendations were eminently sensible and they were never disputed. But it was many years after the introduction of the NHS before they were implemented generally across the country.

Tuberculosis Services

The wasting condition of *phthisis* was recognised since antiquity.⁶² It became common in Britain in the seventeenth century, almost entirely as an urban condition and described by John Bunyan as 'The Captain of the Men of Death.'⁶³ After a period of decline, the incidence of phthisis increased as the industrial revolution progressed and reached its peak in the middle of the nineteenth century becoming the commonest

⁶¹ Ibid., p.199.

⁶² In Europe it first occurred in Europe in the sixth millennium BC at a time of increasing population and domestication of cattle. In primitive societies it was found in agricultural communities and was rare among hunter-gatherers. K. Manchester, 'Tuberculosis and Leprosy in Antiquity and Interpretation', *Medical History*, xxviii, 1984, p. 162.

⁶³ J. Bunyan, *The Life and Death of Mister Badman*. Quoted in the many editions of William Boyd's *Textbook of Pathology* from 1932 and probably in most undergraduate lectures on tuberculosis ever since.

cause of death among adults. It was associated with poverty, as shown in Edinburgh where in, the 1860s, deaths from phthisis (3 per 1000) were most common in the Cannongate and St Giles.⁶⁴ The *British Medical Journal* drew attention to the susceptibility of other social groups 'by the special duties and indoor nature of their duties.'⁶⁵ These groups included seamstresses, tailors, indoor servants and unmarried women living at home. But the most likely to die were married women. A. K. Chalmers, the Medical Officer of Health of Glasgow, in his evidence to the Committee on Physical Degeneration in 1904 demonstrated the relationship with overcrowding; the mortality rate for pulmonary tuberculosis was then 240 per thousand for families living in one room, 180 for families in two rooms and 70 for those in all other houses.⁶⁶

Pasteur had produced some experimental evidence in 1862 that suggested that tuberculosis was an airborne infection,⁶⁷ later proved in 1882 by Robert Koch. Paul Erlich then developed his technique that simplified the bacteriological diagnosis; radiological diagnosis became possible after 1895. In spite of this scientific knowledge it continued to be commonly believed that tuberculosis was an inherited defect⁶⁸ – perhaps understandable since it could be seen that, in repeated close contact within the confines of a home, whole families could often become affected. It was this belief in a hereditary 'taint'⁶⁹ and the observation that, once manifest the disease seemed to be invariably fatal, that together discouraged attempts to find a scheme of rational management.⁷⁰

⁶⁴ Tait, op.cit., p. 58.

⁶⁵ *BMJ*, i, 1892, p.150.

⁶⁶ Chalmers, op.cit., p 96.

⁶⁷ T. B. Conant, *Harvard Case Histories in Experimental Science* ii (Harvard, 1957), p. 509.

⁶⁸ W. Osler, *The Principles and Practice of Medicine* (New York, 1892), p. 192; A. K. Chalmers, *Public Health Administration in Glasgow* (Glasgow, 1905), p. 539.

⁶⁹ A belief still common when I was a medical student.

⁷⁰ A. G. Leitch, 'Two Men and a Bug: One Hundred Years of Tuberculosis in Edinburgh,' *Proceedings of the Royal College of Physicians of Edinburgh*, xxvi, 1996, p. 296.

In 1868 Herman Weber publicised the notion that high mountain air and exposure to the elements could bring about a cure or at least arrest progress.⁷¹ Although there was never any evidence to support this notion the wealthy were attracted to the sanatoria of Davos and other Swiss resorts.⁷² For the poor, who made up the great majority of sufferers, treatment at home, if any, was only palliative.⁷³

By the end of the nineteenth century the deaths rate from tuberculosis had already been falling for over 30 years, possibly due to improvement in social conditions. However, in 1898, increasing public anxiety over health of the race (tuberculosis was the chief killer of young adults) led to the formation of the National Association for the Prevention of Consumption and other Forms of Tuberculosis. By 1904 over 70 sanatoriums had been established in the United Kingdom almost all for private patients. These were based on the practices advocated by Herman Weber; rest and a sound diet were provided but faith rested on the efficacy of fresh air and exposure.⁷⁴ The results in these private institutions are unknown but were probably little different from those in the few charity sanatoriums where the cure rate was 4%.⁷⁵

In Edinburgh, R.W. Philip had already introduced a new system of management in 1887.⁷⁶ At the core of the system was a public dispensary at which possible cases of tuberculosis were examined and assessed. Patients confirmed as suffering from tuberculosis, if in an early stage of the disease could be admitted for isolation in a 'sanatorium' to prevent the spread of disease to others and to prevent secondary infections causing further damage to the patients themselves. Those who improved were transferred to a 'colony' for gradual return towards normal activities

⁷¹ Ibid., p. 12. This notion persisted and influenced sanatorium treatment in the United Kingdom until after the Second World War.

⁷² Leitch, op.cit., p. 13.

⁷³ Malt to counter debility, a mixture of opium, extract of senega and ammonium bicarbonate to control the cough. (Leitch, op.cit., p. 299.

⁷⁴ There is no evidence that such exposure to the elements was beneficial. Sir John Crofton, Professor of Respiratory Medicine and Tuberculosis, Edinburgh University, personal communication.

⁷⁵ F. Smith, *The People's Health 1830-1910* (London, 1990), p. 291.

⁷⁶ Leitch, op. cit., p. 298.

under continuing supervision. Those who seemed unlikely to recover were admitted to a 'tuberculosis hospital.'⁷⁷ Many of those diagnosed at the dispensary refused admission. Men were reluctant to give up work particularly in times of relatively high wages. Mothers were reluctant to leave their families. The proportion accepting admission could be as low as 50%. Others, after admission could not tolerate the regime and discharged themselves.

Although Philip's system was regarded by many as a major advance ('a visionary concept')⁷⁸ it was not introduced nationally until after the National Insurance Act of 1911. A Departmental Committee under Lord Astor, set up to advise on the administration of the Sanatorium Benefit (below), advised that Philip's system should be adopted. The First World War brought an increase in the problem of pulmonary tuberculosis with a larger number of deaths but there were administrative difficulties in introducing the necessary schemes of management. While there were still 309 Public Health Local Authorities with populations varying between 300 and 1,000,000 with existing powers, the National Insurance Act of 1913 conferred powers to take responsibility for tuberculosis schemes on the large burghs and counties rather than on the small rural local authorities, although the existing powers of the local authorities were not repealed. This allowed some authorities to dispute their responsibility. As a further complication, the administration of the Sanatorium Benefit was the responsibility of the Insurance Committee and not the local authority.

In 1920 the Local Authorities succeeded in having the functions of the Insurance Committee transferred to themselves. The new Scottish Board of Health put pressure on the counties to accept responsibility for tuberculosis schemes along with the large burghs. Following a review of the accommodation available for tuberculosis in 1919 the Treasury increased the capital grant to £180 per bed. In 1929 when the Scottish Board of Health was replaced by the Department of Health for Scotland the

⁷⁷ Ibid., 299.

⁷⁸ C.I. Holmes, 'Trial by TB,' *Proceeding of the Royal College of Physicians of Edinburgh*, xxvii, 1997, p. 15.

rationalisation of the administration had been completed; there were 39 dispensaries and a total of 119 hospitals and sanatoriums, 50 with fewer than 50 beds. Until the time of the Cathcart Report the total number of beds remained at little over 5000; the number of dispensaries had increased to 42.⁷⁹

While there was good evidence that the dispensary system was better than what had gone before, the opposition to Philip's earliest proposals for the containment of tuberculosis was entrenched. Sympathetic colleagues advised him 'not to throw himself against a brick wall.'⁸⁰ Gradually however his system demonstrated that the spread of the disease could be confined by isolation of the victims. But while the national death rate from tuberculosis continued to fall, the mortality of those discovered to have active tuberculosis continued to be over 50%. Not all patients could be admitted for treatment and 60% of the women and 50% of the men who died of tuberculosis died at home. Sir Robert Philip's real achievement was not in securing a high cure rate but in showing that tuberculosis was a social disease. The unit to be managed was not only the patient but the whole family and by isolation of the patient, both from family and the community at large, tuberculosis could be contained.⁸¹

When the Cathcart Committee was convened pulmonary tuberculosis was still the commonest single cause of death of young adults, women being more affected than men. In 1933 the overall death rate in Scotland had fallen from almost 170 per thousand at the end of the nineteenth century to 78 per thousand but after a new low in 1935 the rate was rising again in 1936. The true incidence of infection was unknown. While the overwhelming majority of the population became infected early in life, only a few became apparently ill at the time of infection. Most remained symptom free for life; those who suffered clinical disease in adult years were generally those who had come under some physical or emotional stress. Tuberculosis had been notifiable in Edinburgh since 1907 and in Scotland generally since 1914 but there was great and

⁷⁹ *Annual Reports of the Scottish Board of Health and the Annual Reports of the Department of Health for Scotland.*

⁸⁰ Leitch, op. cit., p. 301.

⁸¹ Ibid., p. 303.

persisting reluctance to have the diagnosis recognised because of the considerable social stigma associated with the disease. In most cases the diagnosis was made only when the condition could no longer be denied and therefore 'at a stage when response to treatment is slow or negligible'.⁸² Even in the 1930s the true incidence of pulmonary tuberculosis could only be inferred from the resulting death rate.

The Cathcart Committee, while acknowledging that such tuberculosis services as existed in the early 1930s had undoubtedly been useful, saw that there was need for a radical change in emphasis. There was still no separate legislation for tuberculosis; the existing services operated under old general legislation on infectious disease in which the emphasis was on the protection of the majority by isolating the infectious. Cathcart recommended new legislation that would allow more flexibility, with greater emphasis on prevention and greater support for the patients and families at home.⁸³ In order to make domiciliary services more effective it was recommended that co-operation should be secured between local authority tuberculosis officers and the patient's own doctor, operating in the extended general practitioner service set out elsewhere in the Report. It was recommended that the outpatient tuberculosis services based on the dispensaries, on the Philip model, and developed as special *ad hoc* centres separate from other local authority clinics, should now be brought together with specialist services in other branches of medicine in local authority medical centres. For in-patient services it was found that while the existing total of 5,500 beds was enough it was 'not always adequate in quality'.⁸⁴ Many of the institutions were too small and too poorly equipped to provide services of a satisfactory standard. It was recommended that the existing institutional accommodation should be overhauled and that specialist skills and equipment should be concentrated in regional referral centres.

⁸² *Annual Report of the Department of Health for Scotland*, 1935, p. 84.

⁸³ Cathcart Report, p. 206. This had already been achieved, at least in part, in England by the Public Health (Tuberculosis) Act, 1921 that did not apply in Scotland.

⁸⁴ Cathcart Report, p. 204.

However, Cathcart emphasised that these reformed services should be seen as supplementary to 'to other preventive measures,'⁸⁵ improved housing, better diet and general hygiene. Since the education and co-operation of the public was clearly vital for success, the work of the National Association for the Prevention of Tuberculosis in this field was to be encouraged.

Tuberculosis was the chief killing disease in the young and middle years of life in the 1930s. A cure was not to be even in prospect for another ten years. The Cathcart Committee's plan was, as always, to educate the public to play their part in limiting the spread of the problem and to bring together all the bodies who could contribute to services for the patients under the guidance of a central authority.

School Medical Service.

The School Medical Service had its origins in the findings of the *Royal Commission on Physical Training (Scotland)* of 1903.⁸⁶ The inquiry was commissioned by the Secretary for Scotland to

enquire into the opportunities for physical training now available in the state aided schools and education institutes of Scotland and to suggest means by which training may be made to conduce the welfare of the pupils and further show how such opportunities may be increased in the continuation classes and otherwise so as to develop, in their particular application to the requirements of life, the faculties of those who have left school and thus contribute toward the sources of national strength.⁸⁷

The Royal Commission did find a place for physical training, but as the Secretary for Scotland later explained to Parliament 'the point which has come out most prominently, arose out of their inquiry in a more or less accidental way.'⁸⁸ The members of the Royal Commission had 'felt it our duty to take medical evidence with

⁸⁵ Ibid, p. 206.

⁸⁶ The army had been particularly disappointed by the quality of recruits from Scotland, usually the source of its best physically developed men.

⁸⁷ *Report of the Royal Commission on Physical Training (Scotland)*, op. cit.

⁸⁸ *Hansard*, cxxiv, HC 6 July 1903, col. 1353.

regard to the general physical condition of the youth of the country to ascertain the data which were available for guidance and whether any conclusions might safely be formed with regard to the tendency to advance or decline.' Professor Matthew Hay and Dr. Leslie Mackenzie who carried out the investigations reported that:

There exists in Scotland an undeniable degeneration of individuals of the classes where food and environment are defective which calls for amelioration in obvious ways, [only] one of which is a well regulated system of physical training. School Boards should have command of medical advice and assistance in the supervision of schools; a systematic record of physical and health statistics should be kept. They should provide facilities for the provision of suitable food by voluntary agencies without cost to public funds. If this proves inadequate power should be given to provide a meal and to demand from the parents a payment to meet the cost.⁸⁹

Hay and Mackenzie, shocked by their findings in Leith and Aberdeen, were convinced that similar observations could also be made across the United Kingdom. The Unionist government took no immediate action on the *Report of the Royal Commission on Physical Training (Scotland)* or on the recommendations that were immediately made in Scotland⁹⁰ and no action followed at Westminster in response to the *Report of the Interdepartmental Committee on Physical Deterioration*⁹¹ in 1904.

However, after the election of 1906 the poor condition of school children was taken up by the Scottish Labour member, Arthur Henderson. In the Commons, Henderson recalled the findings of the reports of 1903 and 1904 and emphasised the need for 'the proper and sufficient feeding of children.'⁹² He quoted Leslie Mackenzie

⁸⁹ *Report of the Royal Commission on Physical Training (Scotland)*, 1903, p. 5.

⁹⁰ Following this report the Scottish Royal Corporations produced a *Report on Health Conditions of School Children of Scotland* that proposed that accurate data would help to determine whether or not degeneration of the race was taking place. It urged the examination of children to the highest attainable standards of accuracy including anthropomorphic measurements. This was communicated to the Scottish Secretary apparently without effect. *Minute of the Royal College of Physicians of Edinburgh*, 8 March 1904.

⁹¹ *Report of the Interdepartmental Committee on Physical Deterioration*, 1904, Cd. 2175.

⁹² *Hansard*, clii, HC 2 March 1906, col.1394.

who had reported that 'in the slums of Edinburgh a large proportion of the children were half starved and that to subject half starved children to the routine of school would be the height of cruelty and that the results of education would be poor.'⁹³ A private members Bill was passed without difficulty as the Education (Provision of Meals) Act, 1906. The Act encouraged local authorities to introduce school meals, permitting the cost to be a charge on the rates. In most local authority areas the provision of meals for those in need was organised by voluntary committees with financial support from the local education authority.⁹⁴

In 1907 Robert Morant, as Permanent Secretary to the Board of Education, engineered the inclusion in the Educational (Amendments) Bill of a clause 'to provide for the medical inspection of children immediately before... their admission to a public school and on such other occasion as the Board of Education direct, and the power to make such arrangement as may be sanctioned by the Board of Education for attending to the health and physical condition of children in Public Elementary Schools.'⁹⁵ This legislation for England and Wales slipped through almost unnoticed.⁹⁶ The legislation for Scotland, creating the School Medical Service, came later in the Education (Scotland) Act, 1908, again without significant opposition.

The local education authorities in both parts of Great Britain accepted their new responsibilities with varying degrees of enthusiasm. There was vigorous opposition from parents, many regarding examination of their children as an intrusion on their liberty.⁹⁷ At first the extent of the legal powers of the local authorities to carry out medical examinations was uncertain. An Amendment Act in 1909 established that parents could not be compelled to accept either examination or treatment for their

⁹³ Ibid.

⁹⁴ Voluntary bodies, such as the Poor Children's Dinner Table in Glasgow had been providing meals since 1868.

⁹⁵ Education (Administrative Provisions) Act, 1907, Clause 10 [section 131 (b)]

⁹⁶ B.M. Allen, *Sir Robert Morant: A Great Civil Servant* (London, 1934), p. 231; *Hansard*, clxxix, HC 31 July 1907, col. 1097.

⁹⁷ A group of irate mothers in Glasgow smashed the windows of the Education offices in Glasgow (Macgregor, *op.cit.*, p. 82.)

children and it was made clear that 'there must be reasonable regard for the susceptibilities of parents and child. There must be no attempt to introduce controversial issues such as the pros and cons of vaccination, particular medical theories or fanciful investigations or minute anthropometric measurements.'⁹⁸ The Board of Education instructed that 'the examination should not take more than a few minutes.'⁹⁹

Full medical examinations, as recommended by the *Report on the Physical Condition of School Children in Scotland* in 1903, were therefore never carried out. Instead a quick inspection was limited to finding answers to eight simple questions:

1. Has the child had any illness in the past which would be likely to affect his physical future?
2. What is the present condition of his body as regards cleanliness and nutrition?
3. Are his senses normal – hearing, touch, smell, taste?
4. Has he sound or decayed teeth?
5. Are his throat and tonsils normal and healthy?
6. Is he normal and sound of mind?
7. Does he show any signs of disease or deformity (rickets, tubercle, rheumatism, rupture, glandular disease, ringworm, anaemia, epilepsy, psychoneurosis)?
8. Has he any weakness or defect unfitting him from ordinary school life and physical exercise, or requiring any exemption from any branch or form of instruction?¹⁰⁰

The School Medical Service was crippled from the beginning by the restrictions on its powers and capabilities. It had been observed in 1904 by the Interdepartmental Committee on Physical Deterioration that, in a country which did not have compulsory military service the period of school life offered the only opportunity to 'take stock' of the nation and monitor changes in physical development. The School Medical Service failed to fulfil that function. Not only were no anthropomorphic measurements made, no other appropriate or adequate records were kept. No

⁹⁸ Sir G. Newman, *The Building of a Nation's Health* (London, 1939), p. 202.

⁹⁹ *Report of the Board of Education*, 1909, Cmd. 4566.

¹⁰⁰ Newman, op. cit., p. 199.

statistics relating to the findings of the cursory inspections were attempted for the years before the First World War since 'variation in the methods of tabulating the results made effective collation of statistics impossible.'¹⁰¹ This was only partially rectified in 1914 by the recommendations in Circular No 460 of the Scotch Education Department. The School Medical Service in Scotland did not have an effective record system until 1938.¹⁰²

The brief medical inspections carried out by school medical officers proved useful in officially recognising the blind, deaf and otherwise severely disabled children who could not usefully be accommodated in the normal school system and for whom special provision had to be made. The great majority of the defects that could be discovered in a few minutes of superficial inspection were relatively trivial. The abnormalities discovered in Scotland in 1929¹⁰³ were in line with those that had already been documented in greater detail in the *Report of the Royal Commission on Physical Training* in 1903. In 1904 the School Medical Officer of London, Dr. James Kerr,¹⁰⁴ had also found overwhelming incidence of uncleanness, ringworm, measles, dental decay and defective vision in addition to obvious problems of subnutrition. In addition to subnutrition, the prevalence of defects found in London was as shown in Table 1.

Table 1 School Medical Examinations - London 1904

Verminous	40%	Heart Disease	2%
Dental decay	90%	Tuberculosis	1%
Deafness	5%	Skin disease	1%
Poor Vision	10%	Ear, Nose, Throat Disease	8%

Source: *Report of the School Medical Officer*, London, 1904

¹⁰¹ *Annual Report of the Scottish Board of Health*, 1924, Cmd.2416, p.105.

¹⁰² H. P. Tait, 'Maternity and Child Welfare,' in McLachlan, op.cit., p.428.

¹⁰³ *Annual Report of the Medical Officer of the Board of Health*, 1929, p. 27.

¹⁰⁴ First appointed as Medical Officer to London School Board in 1890; Bradford followed in 1893, and Salford and Halifax by 1904.

There were no comparable statistics from Scotland at that time. Statistics for the whole of Scotland did not become available until 1929. In that year 33.3% of Scottish school children were inspected.¹⁰⁵ (Table 2)

Table 2 School Medical Examinations - Scotland 1929

Poor Nutrition	6.1%	Dental decay	74%
Overt Tuberculosis	0.1%	Hearing Loss	1%
Head Lice	1.8%	Enlarged adenoids	3.9%
Other Vermin	0.8%	Discharging ears	2.4%
Poor Sight	5.8%	Heart disorders	1.9%
Skin diseases	3.7%	Rickets	1.6%

Source: *Annual Report Department of Health for Scotland*

Throughout the 1930s annual reports¹⁰⁶ showed no real change.¹⁰⁷

Since school medical officers had been given no strict basis on which to base their assessments it can only be assumed that the criteria for treatment remained broadly unchanged throughout the 1930s. When school medical inspection was first introduced in Scotland in 1909 it was assumed that it would only be necessary to draw the presence of defects to the attention of parents for appropriate treatment to be arranged by them.¹⁰⁸ However many parents remained unconvinced that treatment

¹⁰⁵ Based on my own many years' experience of Scottish children I find these figures almost incredible. I would have found them surprisingly good even thirty years later.

¹⁰⁶ The figures suggested a slight fall in the incidence of poor nutrition. This was not the experience of one school medical officer in the distressed area of Fife. 'There was on the whole no general decrease in the standard of nutrition and the excellent meals provided at school doubtless prevented deterioration.' *Annual Report of the Scottish Board of Health*, 1927, Cmd.3112, p.187

¹⁰⁷ Appendices VI (i) and (ii); Appendix VII.

¹⁰⁸ *Annual Report of the Scottish Board of Health*, 1924, Cmd. 2416.

was necessary and perhaps even more could not afford the expense involved. Grants for treatment were provided from 1912 and the Education Act of 1918 made it a statutory duty for local education authorities to provide some treatment. The School Medical Service achievements remained modest. Visual defects were identified and spectacles provided; hearing defects were recognised and perhaps managed; cases of heart disease, tuberculosis and rickets were referred to hospital. But treatment in the school clinics was usually for skin and other minor disorders although the extent of the service offered varied widely from authority to authority; the dental service was perhaps the most effective and most widely available.¹⁰⁹ How much was achieved by treatment cannot be accurately known since no records were kept. But in 1924 the Board of Health for Scotland found that treatment was 'still evidently insufficient.'¹¹⁰ On assuming responsibility, the Department of Health for Scotland found that although the School Medical Service had proved helpful, services were uneven and there remained a large body of children with remediable defects 'whose ranks were proving difficult to reduce from year to year.'¹¹¹

The chief difficulty was that the service was administered and financed at local level. This prejudiced the quality of the medical staff recruited. While the medical profession welcomed the School Medical Service in principle, local authorities were regarded as poor and uncertain employers. By 1938, of medical staff of the School Medical Service only 18% held full time appointments. For most the School Medical Service was a fringe activity taken up only to supplement income from other preferred forms of medical practice. There was little opportunity to develop professional skills in the care of children. There was no career structure. As a result the quality of the medical staff remained unimpressive¹¹² and the professional

¹⁰⁹ Appendix VII.

¹¹⁰ *Annual Report of the Scottish Board of Health*, 1924, Cmd. 2416.

¹¹¹ *Annual Report of the Department of Health for Scotland*, 1930, Cmd.3860, p. 70.

¹¹² 'I do not believe that our ablest men and women will look for a career in the School Medical Service.' Sir Charles McNeil, *BMJ*, 28 October 1950, p.1170.

body, the School Medical Officers Association never carried enough weight to force the improvements in the service that were so clearly necessary.

By the late 1930s the School Medical Service employed 233 doctors, 97 dentists, 140 nurses, 20 dental dresser and 10 masseuses providing a service to 3,344 schools and 795,079 pupils. A doctor who had been in the service from the beginning, recorded after 40 years that 'I have long been impressed with the wastage of manpower and money.'¹¹³ The inadequacy of the cursory inspections was revealed by their failure to detect the high incidence of rickets as found by a survey carried out by the Scottish Board of Health in 1925¹¹⁴ or the severity of sub-nutrition found by John Boyd Orr in 1928.¹¹⁵ (The revelation of the poor condition of children evacuated from the cities in 1939 was damning.)

The School Medical Service did not take part, at any time, in prevention schemes. Vaccination against smallpox was never included in the program and when immunisation against diphtheria became available it was not provided. The School Medical Service made no significant contribution to the dramatic fall in childhood deaths from infectious disease in the first decades of the century. (Figure 1.)

Cathcart concluded that the School Medical Service had been 'prevented by legal, and other restrictions from achieving its full potential.'¹¹⁶ It was recommended that the School Medical Service should continue to monitor the state of health of children and to that end the recording of the results of medical inspections should be improved. Cathcart foresaw that, given the extension of the general practitioner service planned in the Report, medical treatment could be provided by the family doctor. It was further recommended that the inspection and supervision of children of school age should become the responsibility of the local authority clinics 'in wide terms, similar to those for maternity and child welfare.'¹¹⁷

¹¹³ *BMJ*, ii, 1950, p. 1001.

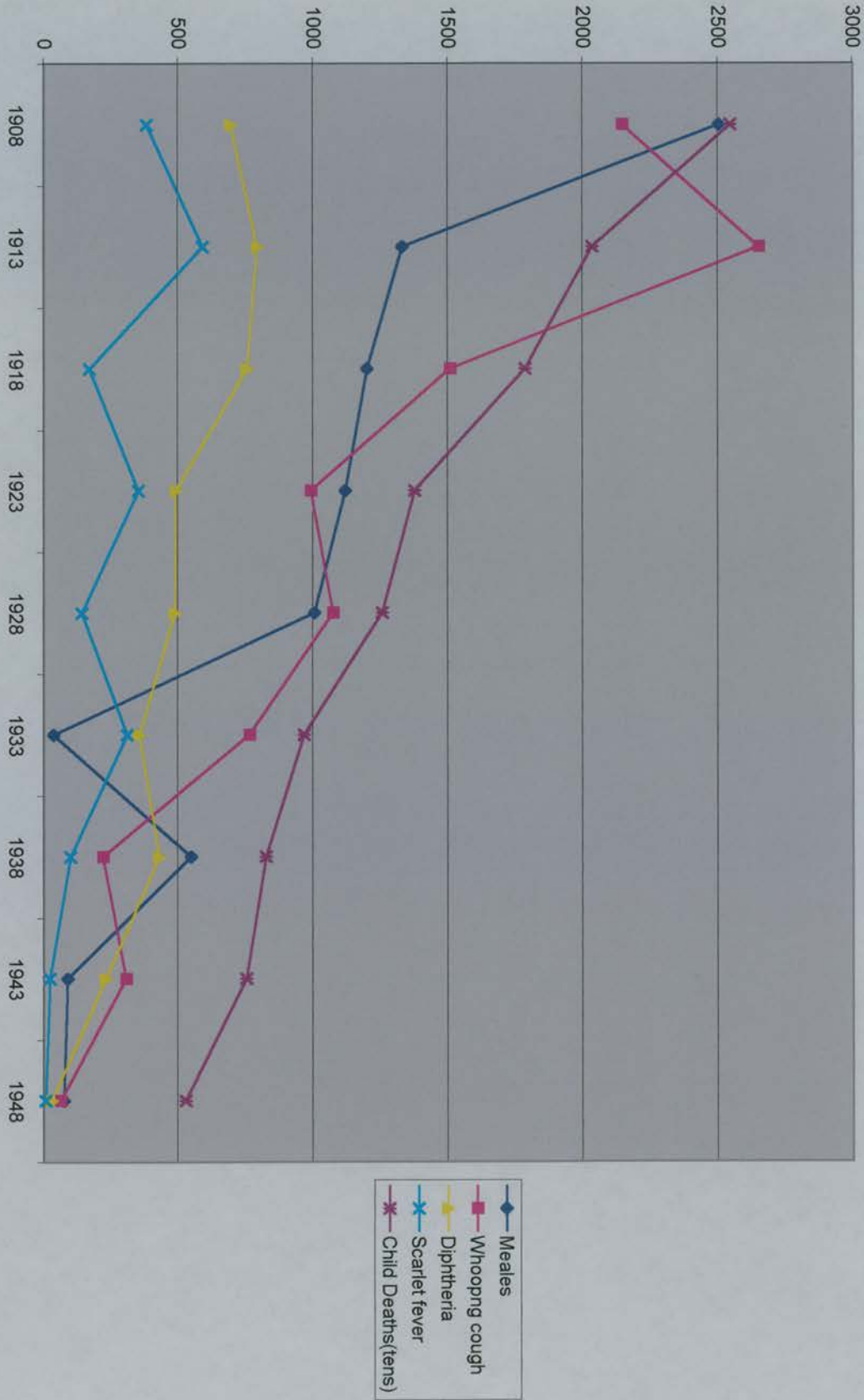
¹¹⁴ *Annual Report of the Scottish Board of Health*, 1925, Cmd.2674.

¹¹⁵ J. Boyd Orr, *Lancet* i, 1928, p. 871.

¹¹⁶ Cathcart Report, p. 192.

¹¹⁷ *Ibid.*, p. 193. For a discussion of these clinics see below.

Infectious Disease and Total Childhood Deaths
Scotland 1908 - 1948



Source: Annual Reports of the Registrar General for Scotland.

It was Cathcart's view that the School Health Services should concentrate on advising on school life - on the curriculum 'so as to strike a sound balance between physical welfare and book work,'¹¹⁸ in choosing the sites and planning the construction of new schools, on the provision of playing fields and other facilities for recreation, on physical training and on health education.

Maternity and Child Welfare.

The Maternity and Child Welfare services were devised early in the century to meet what were then perceived to be two major, distinct but related, threats to the nation - the loss of a great part of its population in the first year of life and the disruption of a great many families caused by the deaths of young mothers.

a) Infant Mortality

The high infant mortality that accompanied the industrialisation of the country reached its peak in the 1870s. In Scotland, the Infant Mortality Rate (IMR),¹¹⁹ even at worst, as in Dundee and Glasgow, was never as high as in England at that time. In the last decades the IMR declined, rapidly in England, more slowly in Scotland. By 1910 the rate was equal in the two countries. But the rate was still enormous at approximately 110 per thousand live births.¹²⁰

For the greater part of the nineteenth century this loss of life was accepted with some equanimity. But towards the end of the century, as the birth rate began to fall there was growing alarm that a reduction in population must inevitably weaken the nation. It was in this context that in 1904 the Interdepartmental Committee on Physical Degeneration expressed its concern that the fall in the IMR had apparently

¹¹⁸ Ibid, p.192.

¹¹⁹ The number of deaths under one year per thousand live births.

¹²⁰ *Annual Abstract of Statistics*

come to an end. It was known that infant mortality was strongly influenced by living conditions;¹²¹ the contemporary view was that 'the answer is in two words, poverty and ignorance'.¹²² In the last years of the nineteenth century voluntary bodies were set up in Scotland, supported in a number of cases by a grant from the local authority, to offer support to young mothers in need. But it was also clear that, apart from the underlying social problems, the chief immediate cause of death of infants was the summer plague of infective diarrhoea. A new generation of Medical Officers of Health, not so caught up in the improvement of public sanitation as their predecessors and supported by better training in bacteriology, turned their attention to this recurring epidemic. In 1901 William Robertson, the Medical Officer of Health of Leith, persuaded his committee to follow the example of the scheme in Fecamp in France, where 'clean' milk was given free provided that the child was brought regularly for examination.¹²³ The first Milk Depot in Scotland was opened in Leith in 1903¹²⁴ followed by others in Glasgow and Dundee in 1904. These Milk Depot schemes were again dependent for their success on voluntary workers.¹²⁵

Accurate information on the survival of infants became available a few years later. In 1876 J. B. Russell, the Medical Officer of Health of Glasgow had found clear evidence that while the death rate among illegitimate children was known to be particularly high, many of these deaths went unreported;¹²⁶ this was particularly true of those who fell victim to 'baby farming'.¹²⁷ Led by A. K. Chalmers, Russell's successor in Glasgow, the country's Medical Officers of Health led a campaign that led to the Notification of Births Act of 1907. This was an adoptive Act that allowed

¹²¹ In Edinburgh at the beginning of the century the infant mortality rate was 38 in Morningside, 54 in Newington, 102 in Haymarket and 344 in the Cowgate. A. D. Fordyce, *The Care of Infants and Young Children* (Edinburgh, 1911), p. 62.

¹²² Ibid, p. 57.

¹²³ W.S. Craig, *Child and Adolescent Life in Health and Disease* (Edinburgh, 1946), p. 158.

¹²⁴ The first in the UK was at St Helens in 1899.

¹²⁵ Checkland and Lamb, op. cit., p. 123.

¹²⁶ J. B. Russell, *Report on Uncertified Deaths in Glasgow* (Glasgow, 1876).

¹²⁷ Parents of illegitimate infants could pay up to £20 to a 'baby minder' to assume total responsibility for the child.

local authorities to require that all births should be reported to the Medical Officer of Health. This was the beginning of legislation for the care of infants. The 1907 Act prompted Edinburgh to appoint an official health visitor and by 1910 this single official was assisted by 300 volunteers.¹²⁸ To varying degrees other local authorities in Scotland followed this example.

In the early years of the First World War there was renewed anxiety about the welfare of young children as many young women found employment outside the home. The IMR began to rise against the trend to 125.5. After a study financed by the Carnegie Trust, Leslie Mackenzie wrote:

The overbuilding of areas, the overcrowding of houses, the urgency of labour demand, the stresses of the labour required, the ill organised food supplies, the sporadic provision for sickness or injury or temporary unfitness – these and the multitude of derivative effects tend, in the aggregate, to destroy the life of the child and to make the life of the mother superlatively difficult.¹²⁹

In 1915 the Notification of Births (Extension) Act was passed, making the notification of births compulsory in every local authority area. The Bill also offered support to Milk Depots and all other voluntary feeding schemes approved by the local authority by a 50% grant from central funds. Further, it now empowered local authorities to ‘make such arrangements as they think fit and as may be sanctioned by us, for the attending to the health of expectant mothers and nursing mothers and of children under the age of five years.’ Local authorities in Scotland differed widely in their willingness to devote scarce financial resources to this new service. But local schemes were established again largely dependent on voluntary support.¹³⁰ At the end of the war this new service was put on a more professional footing. After demobilisation large numbers of well-trained nurses found an opportunity to continue their careers as Health Visitors.

¹²⁸ Tait, op.cit., p. 83.

¹²⁹ W. L. Mackenzie, *Scottish Mothers and Children* (Dunfermline, 1917), p. 17.

¹³⁰ The last voluntary health visitors retired in 1948.

In 1920 the new Scottish Board of Health laid down guidelines for a Maternal and Child Welfare service based on the provisions of the Notification of Birth (Extension) Act and the Midwives (Scotland) Act of 1915. Local authorities were encouraged to develop domiciliary services based on their Maternity and Child Welfare Centres to provide home visits for expectant and nursing mothers and children up to the ages of five. A midwifery service was to be provided if not otherwise available and a medical service for disorders during the pregnancy and neonatal period. At the Welfare Centre medical supervision and advice was to be offered to expectant and nursing mothers and children under five. Some medical treatment and milk and food for mother and child were to be available but the emphasis was to be on instruction on the general hygiene of maternity and childhood. Where possible local authorities were to provide day nurseries, play centres and children's gardens. However the Notification of Birth (Extension) Act stated frankly that 'all local authorities can not be expected to make provision of all the services.' By the end of 1920 there were 165 child welfare centres and 1,162 health visitors; maternity and child welfare schemes, not all complete, had been set up in the districts of local authorities representing 83% of the population.

Thereafter progress was halted. In 1923 the Scottish Health Board reported: 'Our policy over the year, owing to the national financial situation, has been to discourage local authorities from entering into new commitments for extending maternity and child welfare services... We have regretfully had to refuse sanction to many proposals which involved new expenditure ranging from a few pounds a year to very large sums.'¹³¹ By 1936 the number of health visitors (now including school nurses) had fallen to 1085, of whom only 462 were whole-time. The medical staff, except in the largest city centres, were part-time and without specialist training in the care of children. Of the 254 Maternity and Child Welfare Centres, fourteen were entirely voluntary bodies and many others were still dependent on voluntary

¹³¹ *Annual Report of the Board of Health for Scotland*, 1923, Cmd. 2156, p. 52.

assistance. A few unsatisfactory health centres were being closed and no additional centres were planned. This was a small and poorly resourced scheme to provide an adequate service for Scotland's 410,095 children under five. It was also unevenly distributed. In Glasgow local authority services for infants and young children were well organised and led, adequately funded and fully professional.¹³² Glasgow was rivalled by some other large authorities but much of the service in Scotland remained part-time, amateurish and rudimentary.

When Cathcart reported, the death rate of children under five had almost halved during the previous fifteen years; the IMR had fallen from 110 at the end of the war to 77.¹³³ Much of this improvement must be attributed to the improvement in living conditions and the control of infectious disease.¹³⁴ In England, enjoying overall a better recovery from the effects of industrialisation, the IMR had fallen to 57 with the rate in the industrial north at 67 and in Wales at 63.

The part played by local authority services must remain a matter of speculation. But it is remarkable that, in Scotland, the worst infant mortality rates were not in the great cities but in the industrialised counties (Renfrew IMR 85) and in the industrial burghs (Coatbridge IMR 94). It seems unlikely that social conditions in these towns were significantly worse than in the cities. The high infant mortality suggested that local services were less well organised than those of the large city Health Departments.

In 1936 the Cathcart Committee did not discuss the shortcomings of the services for infants and young children in depth or at length but gave the clear verdict that they were generally unsatisfactory. The Report found that the statutory schemes had been 'seriously handicapped'¹³⁵ in their work by the inadequacy of the

¹³² O. Checkland and M. Lamb (eds.), *Health Care as Social History: The Glasgow Case* (Aberdeen, 1982), p.131.

¹³³ *Annual Report of the Department of Health for Scotland, 1936*, Cmd.5407, p.152.

¹³⁴ The Infant Mortality Rates are quoted from the *Annual Reports of the Registrar General for Scotland*.

¹³⁵ Cathcart Report, p. 182.

domiciliary nursing and medical services for infants. There were also ‘serious gaps’¹³⁶ in the clinic arrangements for children under five. It recommended that the domiciliary services should be absorbed into the new extended general practitioner service proposed elsewhere in the Report. It was also recommended that the out-patient clinic arrangements for children under five should be combined with those for school children in a single local authority service for children.

b) Maternity Services

In the mid-1930s the loss of young mothers from the disorders of childbirth had become a scandal.¹³⁷ The Maternal Mortality Rate¹³⁸ hardly reflected the extent of the problem, the persisting disability and ill health that often followed delivery and the devastation of the families when the mother died.¹³⁹ In 1880 maternal mortality had been high in all social classes and particularly high in the lying-in hospitals where the death rate could be up to ten times that for deliveries at home. The introduction of first anti-septic techniques and then asepsis brought a general reduction in deaths from puerperal sepsis, and a spectacular reduction in maternal deaths in hospital practice. By 1900 the risk of puerperal sepsis was less in hospitals than in home deliveries and it seemed that maternal mortality could be further reduced by more rigorous application of anti-sepsis during home deliveries. In the United Kingdom the Midwives Act of 1902, enforcing the regulation of midwives, was intended to ensure that properly trained care would be generally available.

But, contrary to expectation, in the first years of the century the Maternal Mortality Rate (MMR) began to increase. In Scotland the MMR in the first decade

¹³⁶ Ibid.

¹³⁷ I. Loudon, ‘Some International Features of Maternal Mortality,’ in V. Fildes, L. Marks and H. Marland, *Women and Children First* (London, 1992), p. 10.

¹³⁸ The number of deaths in pregnancy, delivery and the postnatal period per 1,000 births.

¹³⁹ The problems were not unique to Britain. The scandal affected most of Western Europe and the United States.

averaged 5.6. In England the rate varied widely from region to region (the rates in the north west of England like those in Wales followed the pattern in Scotland) with an overall rate of 5.02 in 1908.¹⁴⁰ By 1918 the MMR in England had risen to 7.6¹⁴¹ and in Scotland to 7. Thereafter the MMR continued to rise in Scotland while in England it remained more or less constant.¹⁴²

The local authority services introduced following the Notification of Births (Extension) Act of 1915 brought no improvement. In 1928 the British College of Obstetricians and Gynaecologists¹⁴³ was founded with a view to improving the standard of obstetric care. However more intensive management of the delivery did not prove to be the answer. In 1933 a scheme in Rhondda that increased the part played by doctors in the management of the delivery conspicuously failed to improve the MMR.¹⁴⁴ In 1935 the *Report on Maternal Morbidity and Mortality in Scotland* made the disconcerting judgements that: 'the general level of ante-natal care is unsatisfactory',¹⁴⁵ and 'there is no doubt that one of the most disquieting features of present-day obstetrics is hurried and unnecessarily meddlesome midwifery.'¹⁴⁶

In retrospect it is possible to offer a partial explanation of the greater problem in Scotland. In part the difference was due to the larger proportion of 'at risk' pregnancies in Scotland. The risks of pregnancy increase with maternal age and with the number of previous pregnancies.¹⁴⁷ Both of these factors were greater in Scotland at this time. (Birth rates for mothers aged 30-34 was 98.2 in Scotland compared with 81.4 for England and 60.42 between the ages of 35 -39 in Scotland compared with 46.6 for England). From the late 1930s the proportion of "high risk" pregnancies in

¹⁴⁰ A. Macfarlane and M. Mugford, *Birth Counts* (London, 1984).

¹⁴¹ The figures given for 1908 and 1918 are both in accordance with the classification used before 1911 and are used to show the rise from 1908.

¹⁴² *Report on Maternal Morbidity and Mortality in Scotland*, HMSO, 1935)

¹⁴³ The predecessor of the Royal College of Obstetricians and Gynaecologists founded in 1938.

¹⁴⁴ H. Jones, *Health and Society in the Twentieth-Century Britain* (London, 1994), p. 65.

¹⁴⁵ *Report on Maternal Morbidity and Mortality in Scotland*, op.cit., p. 16.

¹⁴⁶ *Ibid.*, p. 27.

¹⁴⁷ *Ibid.*, p. 8.

Scotland became smaller as the average family size became smaller, the average age of mothers became less, and the number of abortions became smaller. These changes were accompanied by a fall in the MMR.

Other widely acknowledged factors were equally important. Poor social conditions and inadequate antenatal care were major factors. In the early years of the century J. W. Ballantyne of Edinburgh¹⁴⁸ and Chalmers of Glasgow¹⁴⁹ had both emphasised the importance of a proper diet for the mother. An experiment in Rhondda in 1935 confirmed that the distribution of food to the women attending antenatal clinics would cause a dramatic fall in the MMR. From the mid-1930s better attention to the nutritional and antenatal care of the mother no doubt helped to reduce the MMR in Scotland.

It had been noted in 1935 that the meddlesome midwifery practised by general practitioners was less safe than management by a midwife (above). At that time the observation by Geddes in 1912,¹⁵⁰ that in industrial areas general practitioners, in their daily practice, frequently dressed wounds infected by the streptococcus and became dangerous carriers of the streptococcus, had not become generally known. (The situation changed radically after 1935 when Prontosil was discovered and followed by the development of a series of sulpha drugs. From 1936 streptococcal infections could be effectively treated and the death rate from puerperal sepsis and the MMR fell dramatically.¹⁵¹)

When Cathcart reported Scotland's MMR was still high at 6.2. In 1935 the Ministry of Health was satisfied with the overall rate for England and Wales (MMR 4) but launched investigations of the relatively poor rates in Lancashire and West Yorkshire and the burghs of Halifax and Rochdale. In Scotland, as has been stated, the worst results were in the industrial areas, not in the great cities where local authority

¹⁴⁸ J.W. Ballantyne, *Manual of Ante-natal Pathology and Hygiene* (Edinburgh, 1904).

¹⁴⁹ A.K. Chalmers, *Proceedings of the National Conference on Infant Mortality*, (Liverpool, 1914).

¹⁵⁰ G. Geddes, *Statistics of Puerperal Sepsis and Allied Infectious Diseases* (Bristol, 1912).

¹⁵¹ *Annual Reports of the Registrar General for Scotland*.

services were well organised, but in the county of Renfrew (MMR 8.5) and in the burgh of Coatbridge (MMR 12).¹⁵²

Since the causes of these high maternal mortality rates were then unknown, the Cathcart Report urged that every maternal death should be carefully investigated. But even without a clear understanding of the problem the Cathcart Report recommended a new comprehensive maternity service. In this the general practitioner was to be central, giving continuous supervision of his own patients throughout pregnancy, delivery and puerperium. General practitioners were to act in concert with the local authority staff of full-time properly trained midwives. This midwifery service was to be based in local authority clinics at which consultant advice and diagnostics services would be available. Since particular reliance was to be put on midwives, it was recommended that their remuneration, conditions of service and status should be increased. Cathcart made the somewhat controversial recommendation that the local authority maternity service should include advice on contraception.¹⁵³ Hospital facilities were also to be improved with all obstetric units large enough to justify the employment of a resident medical officer.

National Health Insurance

The National Health Insurance scheme came as a sudden and unexpected diversion from what was then thought to be a promising momentum in the development of state medical services. The Royal Commission on the Poor Laws and the Relief of Distress, set up by the Unionist government in its last months of office in 1905, was intended to meet rising public concern over the increasing burden of pauperism by strengthening the existing provision for its management. When the Commission reported in 1909,

¹⁵² Figures calculated from the *Annual Reports of the Registrar General for Scotland* and the *Registrar General's Statistical Review*, 1940.

¹⁵³ Cathcart Report, p. 178.

the Majority Report was in line with this intention. The Minority Report however advocated the abolition of the Poor Law and its services, and the creation of a new state medical service that would serve a very much greater section of society.¹⁵⁴ This proposal for a state medical service had powerful support from the government's chief medical advisers. George Newman, Chief Medical Officer of the Board of Education and Robert Morant, its Secretary, had assisted in the preparation of the Minority Report. Arthur Newsholme, the recently appointed Chief Medical Officer of the Local Health Board was also known to favour the proposed new service.¹⁵⁵

In Scotland the *Edinburgh Medical Journal* immediately expressed support for the Minority Report.

Of the fourteen Commissioners who signed the Majority Report five sign it with not unimportant reservations...The Minority Report is signed by four unanimous Commissioners. Counting heads is not a final test of authority. In two recent Royal Commissions within the last twelve years Minority Reports became the accepted reports of the general public and if unity of purpose and closeness of analysis are to count for anything, the Minority Report has all three.¹⁵⁶

The *Edinburgh Medical Journal* went on later to published a plan for a National Medical Service 'analogous to State Education or the National Post Office.'¹⁵⁷

In England the response was slower. The *British Medical Journal* delayed its response until July 1909. It then supported the Majority for its own particular reasons. The *British Medical Journal* was a respected scientific journal but in its political sections it was the creature of the officers of the BMA who, in 1909, were struggling to become the accepted voice of the medical profession.¹⁵⁸ The Majority Report offered them an opportunity for power as the medical representatives on the proposed Medical Assistance Boards. But, as was to be the case on many occasions, the hierarchy of the BMA did not have the support of the profession or even of the

¹⁵⁴ At that time the Poor Law served only 2% of the Scottish population.

¹⁵⁵ Sir A. MacNulty, *The History of State Medicine in England* (London, 1948), p. 71.

¹⁵⁶ *Edinburgh Medical Journal*, vi, 1911, p.14.

¹⁵⁷ *Ibid.*, p. 311.

¹⁵⁸ Discussed in a later chapter.

majority of their own members. At the Annual Representative Meeting of the BMA in 1910, the officers were instructed to take the more progressive line of the Minority Report.¹⁵⁹ By 1911 the officers of the BMA reluctantly responded to these instructions and began to prepare 'for legislation along the lines of the Webb report.'¹⁶⁰

The *Edinburgh Medical Journal's* proposal for a National Medical Service in line with the Minority Report had just been published in April and the BMA plan was still in preparation when suddenly the full content of Lloyd George's National Insurance Bill became known at its first reading on 4 May 1911. Even to Sir George Newman, Chief Medical Officer of the Board of Education the Bill came 'out of the blue.'¹⁶¹ The proposed National Health Insurance Scheme cut across the planning within the medical profession. The profession was already looking for a comprehensive reform of the country's system of health care that would address the great health problems of the country as a whole.¹⁶² Lloyd George was coming from a different direction.

As became generally known later, Lloyd George had been in consultation with the Friendly Societies and the commercial insurance interests since 1908.¹⁶³ His aim was the relief of poverty. He had studied the situation in Germany where Bismarck's legislation between 1880 and 1884 had introduced compulsory insurance of industrial workers against sickness, employers' liability in accidents and old age pensions. Lloyd George expressed his enthusiasm for these schemes when he visited Germany in 1908. He began work on a scheme of his own which he later described as 'the logical outcome of the Old Age Pensions Act and that having made provision for those over 70 years of age, the Government desired to make provision

¹⁵⁹ *BMJ*, i, 1910, p. 273.

¹⁶⁰ A. Cox, *Among the Doctors* (London, 1950), p. 85

¹⁶¹ Newman, *op.cit.*, p. 390.

¹⁶² *Edinburgh Medical Journal*, vii, 1912, p.1.

¹⁶³ B. Gilbert, *The Evolution of National Health Insurance in Great Britain* (London, 1966), p. 314.

for the workers of both sexes who are incapacitated before reaching the pension age.’¹⁶⁴

Lloyd George’s Bill was complex and touched on many interests. Modification of the Bill continued beyond the Second Reading at the end of May. As has been described in Chapter One, following a last minute amendment to the Bill, a separate National Insurance Fund and Commission were established for Scotland. The National Insurance Act received Royal Assent on 16 December 1911. The Scottish Insurance Commission took up its duties on 1 January 1912.

The Act brought in an insurance scheme¹⁶⁵ compulsory for persons employed under a contract of service in manual labour and open, on a voluntary basis, to non-manual workers whose annual or remuneration did not exceed £160 a year.¹⁶⁶ In addition to a cash benefit (sickness or disablement) during periods of incapacity for work and a maternity benefit of £2 to be paid on the confinement of an insured woman or the wife of an insured man, every insured person was entitled to medical treatment by a general practitioner.¹⁶⁷ The doctor was required to provide ‘all proper and necessary medical services other than those involving the application of special skill and experience of a kind which general practitioners as a class cannot reasonably be expected to possess.’¹⁶⁸

The cash benefits were administered by Approved Societies – usually Friendly Societies, Trade Unions or industrial insurance companies, often ‘international’ bodies managed from England. Each Approved Society was a separate financial unit, which, if found to have a surplus at each quinquennial valuation, could provide additional benefits either as increased cash payment or as additional medical services

¹⁶⁴ Lloyd George, quoted in Gilbert, *op.cit.*, p. 292.

¹⁶⁵ Described in Chapter One, p. 3.

¹⁶⁶ Raised to £250 by the time of the Cathcart Report

¹⁶⁷ There was also an ill-defined tuberculosis benefit that offered no more than was already generally available in Scotland. Braithwaite suggests that Lloyd George’s concern about tuberculosis was the result of his own fear of the disease.

W. Braithwaite, *Lloyd George’s Ambulance Wagon* (London, 1957), p. 71.

¹⁶⁸ Cathcart Report, p. 216.

such as dentistry, ophthalmic services or additional medical support.¹⁶⁹ The statutory medical services were administered in Scotland initially by 39 local insurance committees (54 by the time of the Cathcart Report) under the supervision of the Scottish Insurance Commission. Every qualified medical practitioner in Scotland had the right to be included in the panel of insurance medical practitioners and to accept up to 2,500 insured persons on his list;¹⁷⁰ for each person on his list he received a capitation fee of 9s.

In Scotland the National Health Insurance scheme was generally welcomed although employers had some early reservations:

The Chancellor of the Exchequer's great scheme of State insurance has had a very remarkable reception, which divides itself into two moods following a very unusual line of cleavage. On the one hand we have the politicians of all parties, the newspapers of almost all categories, and representatives of the working classes of all trades and grades, welcoming it effusively. There are, of course, the inevitable and altogether proper reserves. Details must be examined with critical care, actuarial wisdom must be consulted and deferred to, machinery must be closely scanned. But as regards the thing aimed at, the classes referred to are almost of one mind. On the other hand stand the businessmen. They cannot as a class be described as hostile, but their attitude is distinctly that of disturbance.¹⁷¹

There can be no doubt that the National Insurance scheme accomplished Lloyd George's immediate aim. It helped towards limiting poverty in the years of economic depression and unemployment in the twenties and thirties. At the end of his authoritative study Gilbert concludes that this 'compulsory self insurance has provided the armour that allows the increasingly desperate, but still free, human atom to live in an ever more complex and oppressive industrial society.'¹⁷²

But the contribution of the National Health Insurance Scheme to the health of the nation or even of the working population was negligible. The scheme came

¹⁶⁹ The Post Office scheme did not accumulate such funds.

¹⁷⁰ Few Scottish practices had lists of over 500. In 1913 the largest list, in Dundee, was 1,638.

¹⁷¹ *Dundee Advertiser*, 6 May 1911.

¹⁷² Gilbert, *op.cit.*, p. 452.

quickly into operation in Scotland. With the exception of Edinburgh and four areas in the Highlands, panels of general practitioners had been set up across Scotland in time for the initiation of medical benefit on 1 January 1913. There were already 102 Approved Societies in place and recognised by the Insurance Commission; 51 of these were new creations founded specifically to take part in the scheme. Development of the scheme was inhibited by the First World War. By 1919 the number of Approved Societies had been rationalised and reduced to 75. Some 21% of the population of Scotland were then contributing members of the scheme; of these contributors 49% were members of Friendly Societies, 38% of Industrial or Colliery schemes and 12% of Trade Union schemes.¹⁷³ There were 17,340 deposit contributors.¹⁷⁴ Over the years the number of Approved Societies was further reduced to 69. The total membership increased to 45% of the population of Scotland; the proportional distribution of members across the Friendly Societies, industrial insurance schemes and Trade Union schemes remained almost unchanged while the number of deposit contributors fell below 16,000. By late 1930s the National Health Insurance scheme had extended to provide a service to a very large section of Scottish society.¹⁷⁵ But that service was very limited and for many families the National Health Insurance Scheme had resulted in a reduction of medical care. Before 1913, many workmen, by a weekly deduction from their wages, had contributed to a works or other medical scheme that provided medical services for themselves and their families. Such schemes were displaced by National Health Insurance. Families now went without medical provision unless a second subscription was made to an appropriate special scheme provided by a trade union or other body or to a club organised by a general practitioner.¹⁷⁶

The care provided by the general practitioner for the insured workmen was itself limited by the Medical Benefit Regulations of 1920 which laid down that no

¹⁷³ *Annual Reports of the Scottish Board of Health*; T. Johnston, *The History of the Working Classes in Scotland*

¹⁷⁴ *Annual Report of the Scottish Board of Health*, 1919, Cmd. 825.

¹⁷⁵ *Annual Reports of the Department of Health for Scotland*.

¹⁷⁶ A. Digby, *The Evolution of British General Practice* (Oxford, 1999), p. 317.

insurance practitioner would receive payment in respect of any procedure that was held to be 'beyond the competence of a general practitioner of ordinary professional competence and skill.'¹⁷⁷ In a succession of rulings it was established that such emergency procedures such as appendicectomy or other minor surgery, including tonsillectomy or excision of tuberculous glands, were considered to be beyond the ordinary competence and skill of a general practitioner. For many practitioners in Scotland whose patients did not have ready access to hospital these had been routine domiciliary procedures. Since they were not financed by the NHI Scheme, the subscriber and his family still had to pay for such procedures carried out at home unless the doctor provided his services free.

A small proportion of the population of Scotland (4.4% by 1929) were entitled to hospital treatment as an additional benefit of membership of an Approved Society with actuarial surpluses. This very small service was thought to be tolerable since 'the great majority of insured persons in need of hospital treatment are accommodated in the large voluntary hospitals and are treated free of charge.'¹⁷⁸ However, for patients living at any distance from the main centres of population treatment in a voluntary hospital was not readily available. For them the restrictions on the services to be provided by general practitioners under the Medical Benefit Regulations resulted in a poorer service and many non-emergency surgical conditions went untreated.¹⁷⁹

By the end of the 1930s, 24.8% of the insured population were entitled to dental treatment and 25% to ophthalmic services as additional benefits. 21.8 % could receive appliances such as trusses, elastic stockings and other supports as additional benefits.¹⁸⁰ The range of these additional services, financed by Approved Societies, increased very little following their introduction after the war; the Approved Societies

¹⁷⁷ *Annual Report of the Scottish Board of Health*, 1921, Cmd.1697, p. 153.

¹⁷⁸ *Annual Report of the Department of Health for Scotland*, 1929, Cmd.3529, p. 154.

¹⁷⁹ Families were also liable for a fee when a doctor was required at maternity cases. The fee was usually greater than the Maternity Benefit from NHI and in the working class culture of the time, it was invariably paid.

¹⁸⁰ Figures calculated from the *Annual Report of the Department of Health for Scotland*, 1939.

had been advised against using surplus funds to extend their services in 1913 and again in 1921.¹⁸¹ In 1922 the need for further economies in public spending diverted the funds of the Approved Societies away from increasing their benefits:

The need for economy in the national expenditure was a special feature of the year common to all public services and led to an intensive scaling down of the whole field of National Health Insurance administration. Approved societies have accepted a full share of responsibility by shouldering till the end of 1923 the portion of the cost of medical benefit and related services formerly borne by special Exchequer grants.¹⁸²

In 1927 a Memorandum of the Department of Health recorded an increase in sickness and disablement 'so continuous and of such magnitude as to cause concern among all engaged in the administration of these benefits.'¹⁸³ The rapid rise in the total reported sickness reached a peak in 1929 but accurate statistical accounting of the morbidity of the insured population did not begin until 1930; useful reviews were first published in 1934. Accurate figures in 1936 show that the total amount of sickness in the insured population had risen to the equivalent of 11 days for every insured person. The Department of Health for Scotland noted that the complaints being treated under the National Health Insurance scheme were 'not, in the main, those that were serious or life-threatening, but influenza, digestive disorders, rheumatism and skin conditions.'¹⁸⁴ It was also noted that apart from these specific disorders

much sickness is attributable directly or indirectly to general factors—housing, defective diet, poverty in the wide sense and the deleterious effects of occupational environment. Personal factors such as unhygienic habits, occupational misfits and maladjustments are not less important. Part of the high level of sickness can be attributed to the effects of unemployment which each act adversely though in totally different directions; unemployment when prolonged, leading to

¹⁸¹ *Annual Report of the Scottish Board of Health*, 1921, Cmd. 1697, p.153.

¹⁸² *Annual Report of the Scottish Board of Health for Scotland*, 1922, Cmd. 1887, p.56.

¹⁸³ Quoted in R. Harris, *National Health Insurance*, (London, 1946), p.113.

¹⁸⁴ *Annual Report of the Department of Health for Scotland*, 1936, Cmd. 5407, p.15.

disabilities often of a psychoneurotic kind, re-employment producing such sequelae as accidents, myalgias and superficial sepsis.¹⁸⁵

The increase in trauma was also giving problems:

The task of providing adequate treatment facilities for persons accidentally injured is rapidly becoming a serious problem. Violence accounts for approximately 10% of the certified causes of incapacitating sickness. This increasing accident incidence raises problems regarding provision for adequate, sometimes highly expert, treatment of the injured and the effect of the pressure of accident cases on available hospital accommodation.¹⁸⁶

On reviewing the achievements of the National Health Insurance Scheme, there is no evidence that it brought about an improvement in the nation's health. This had not specifically been set as a primary objective. Improvement in the nation's health could only have been hoped for, if at all, as an ultimate and long-term benefit. In the event, by 1936, the National Health Insurance scheme was barely able to fulfil the very modest role it had been given to safeguard the workman's fitness to work and lessen the chance of his family falling into poverty.

While the effect of the National Health Insurance scheme on health was negligible, the effect on the organisation of personal health care was considerable. It was not only important in the development of medical services in the United Kingdom but in confirming the separate development of services in Scotland it was crucial.

The 'Six Cardinal Points,' demanded by the medical profession for inclusion in National Health Insurance Bill, were part of the long struggle of the medical profession against the humiliations of 'contract practice'. In the new scheme the undertaking between doctor and patient was to be by mutual agreement and, in essence, a private contract. The scheme offered reasonable security of employment with an income that varied from almost £250 for the average practitioner in a rural

¹⁸⁵ Ibid. p. 16.

¹⁸⁶ Ibid.

area to over £700¹⁸⁷ in a few large city practices. For almost all general practitioners in Scotland this was a very desirable package; some 2,000 had joined at once, even while the leaders of the BMA continued to battle for greater concessions. Panels in Scotland were made up twice as fast as in England. At a stroke, on 1 January 1913, the great majority of Scottish doctors had become dependent on the state for their employment.¹⁸⁸

Unlike its Irish counterpart, which had been created for specified reasons and had had the benefit of careful planning, the responsibilities initially assigned to the Scottish Commission were ill-defined; it was 'little more than a declaration of intent.'¹⁸⁹ In view of the small number of established Friendly Societies in Scotland the Commission was given power to initiate County Approved Societies where a need could be shown. Authority was also given to adapt services and benefit levels on grounds of 'sparseness of population, difficulties of communication, or other special circumstances'. Deficiencies and lack of specific direction in the Act allowed opportunities for interpretations of the Act that were specifically Scottish. The Scottish Commission found its own solution to such problems as the position of share fishermen who were not clearly employees or self-employed; of farm workers who, by custom, already received some support when sick;¹⁹⁰ of Highland crofters who were both self-employed and employees.

In 1926 The Royal Commission on National Health Insurance¹⁹¹ recommended 'urgently desirable' extension of the statutory medical benefits. It recommended: a) that the medical services should include specialist advice, dental treatment and laboratory diagnostics services, b) that the maternity benefit should

¹⁸⁷ Figures calculated from the First Report of the Insurance Commissioners, *BMJ*, i, 1913, p. 69.

¹⁸⁸ They remained the lowest paid profession with the exception of teaching, and still, according to Bernard Shaw, 'hideously poor.' (*Doctor's Dilemma*, 1927)

¹⁸⁹ Gilbert, op cit. p. 421.

¹⁹⁰ A difficulty that led to the incident described by Fenton in *The Turra Coo* (Aberdeen, 1989).

¹⁹¹ *Report of the Royal Commission on National Health Insurance*, 1926, Cmd. 2596.

include medical and midwifery services, c) that these extended medical benefits should be provided for the dependants of those receiving sickness or disablement benefit. Due to the prevailing financial climate these recommendations came to nothing.

In 1936 the proposals made by Cathcart were more fundamental. Cathcart concluded that the most urgent need in Scotland, both in the interest of the health of the people and as a matter of administrative expediency, was that the services of the National Health Insurance Scheme should be extended 'to all classes in need.'¹⁹² As part of radical reform of medical services in Scotland, Cathcart recommended that the administration of this extended contributory medical insurance scheme should continue on the same model, retaining the panel system, capitation fees and the part-time engagement of general practitioners, but should be administered by the local authorities. This change in administration was recommended to overcome what was seen as one of the principal weaknesses in the organisation of medical services by integrating general practitioner services with those being developed by the local authorities.

In July 1936 the *British Medical Journal* reported, with approval, the comment by Arthur Greenwood in a question to the Minister of Health during the debate on the Estimates:

The social services that had been built up over the three or four generations were one of our greatest national achievements but they had not been conceived as a perfectly co-ordinated system. They had been built up clumsily to meet instant social evils as they had printed themselves on the public mind.¹⁹³

Greenwood's comment was made to the House of Commons within a very few weeks of the presentation of the Report of the Committee on Scottish Health Services and was an epitome of judgements made in the Report. However the emphasis in the

¹⁹² Cathcart Report, p. 220.

¹⁹³ *BMJ*, ii, 1936, p. 204.

Report was on the recommendations for reform. It seems evident that the Committee found it politic not to dwell on the extent of the failures of the state services. A full exposition would have inevitably implied criticism of government and invited rejection of the Report and its proposals.

The failures of these services were the result of poor initial planning, unevenness in implementation and lack of resources and, in some cases, the reluctance of the public to take full advantage of the service on offer.

The inspections carried out by the school medical service, as result of the restrictions imposed by parents, were no more than superficial; carried out by poorly trained staff even these inspections were inadequate. In 1935 routine inspection were carried out on 28.8% of Scotland's school children; the proportion found to have defects remained virtually unchanged since the service began,¹⁹⁴ and there was no certainty that the abnormalities discovered would be treated. Because of the refusal of some local authorities to meet the cost of transportation,¹⁹⁵ in 1935 milk was being offered to only 42% of Scottish school children and of these only 51% could be persuaded to take it.¹⁹⁶

The guidance and support offered by maternity and child welfare clinics no doubt contributed to the fall in the infant mortality rate which, in 1935, reached a new low at 76.8. Nevertheless, while the great majority of the new born were visited at home, only 37% of Scottish mothers made use of the services of a welfare clinic during their child's first year. Although numbers had increased substantially over the previous ten years, only 35% of Scottish mothers attended local authority antenatal clinics in 1935 and the Maternity Mortality Rate at 6.3 was almost twice that for England and Wales.

In 1935 the incidence of infectious disease¹⁹⁷ was rising in Scotland, increasing by a further 16% in 1936. The number of deaths from pulmonary

¹⁹⁴ *Annual Report of the Department of Health for Scotland*, 1935, Cmd., 5123, p.75.

¹⁹⁵ And in some schools teachers were uncooperative.

¹⁹⁶ *Annual Report of the Department of Health for Scotland*, 1938, Cmd. 5969, p.56.

¹⁹⁷ Other than tuberculosis.

tuberculosis in 1935 was also greater than in 1934; the achievements of the tuberculosis service were limited by the inability of patients to accept treatment over the many weeks required; fathers could not afford to give up work and mothers could not find care for their children; the proportion of patients accepting treatment in Scotland seldom rose above 50%¹⁹⁸

The National Health Insurance scheme, although it offered only limited services to 41.4% of the population of Scotland, was never financially in a position to improve its services in line with advances in medicine or to extend its services to a larger proportion of the population. Because of rising unemployment it was already financially unsound by 1920 and had been propped up by no fewer than eight Acts of Parliament even before the first Actuarial Report and the National Health Insurance and Contributory Pensions Act of 1935.¹⁹⁹

While the Cathcart Report made constructive proposals for the improvement of these state medical services it did not make clear the true extent of the problems to be overcome in Scotland.

¹⁹⁸ *Annual Reports of the Scottish Board of Health, Annual Reports of the Department of Health for Scotland.*

¹⁹⁹ *Annual Report of the Department of Health for Scotland, 1935, Cmd. 5123. p.107.*

CHAPTER SEVEN

THE HOSPITALS

It was widely recognised during the inter-war years that there were inadequacies in Scotland's hospital services, due principally to a shortage of beds.¹ This had been the conclusion of a number of reviews carried out since the creation of the Scottish Health Board.² From its first years, the Board had encouraged the voluntary hospitals, the local authorities and the several medical organisations in Scotland to co-operate in making the best use of all available resources. It had become widely accepted that there must be a single deliberate and active policy in Scotland for the creation of a more effective hospital service.³ The Cathcart Committee was able to build on this consensus in producing its plan for the future.

In England and Wales there was no such consensus. There the development of hospital services had a history that made disharmony inevitable. Evolution over centuries had produced different hospital systems with very different priorities causing rivalries and gross inequalities in hospital provision across the counties and boroughs. Although Scotland remained on the sidelines as interests clashed south of the border, the compromises eventually reached in the resolution of England's problems in the creation of the National Health Service were to be influenced by the proposals made by the

1. 'Beds' in this context includes the staffing and equipment to service them to a satisfactory standard.

² *A Scheme for Medical Services for Scotland* (MacAlister Report) 1920, Cmd.1039; *Report of the Hospital Services Committee* (Mackenzie Report), HMSO 1926, *Report on Hospital Services* (Walker Report), HMSO 1933; *Annual Report of the Department of Health for Scotland* 1934, Cmd. 4837, pp. 91-97.

³ Cathcart Report, p. 233.

Cathcart Committee for Scotland.⁴ It was also inconceivable that Cathcart's scheme could have been put in place in Scotland without reference to decisions being made for England and Wales. It was highly improbable that Westminster would legislate for fundamentally different hospital services for two parts of the United Kingdom. The full significance of the recommendations made by the Cathcart Committee for Scotland is therefore best understood against the background of events in England.

Hospitals in England and Wales

The leaders in hospital services in England and Wales, in standards if not in numbers, were the large city voluntary hospitals. After the First World War their numbers had increased and England had become 'littered'⁵ with small voluntary hospitals. These small hospitals had proliferated particularly in rural areas to serve small communities. Almost half of all the voluntary hospitals in the English provinces were of 40 beds or less.⁶ It appeared to the Voluntary Hospitals Commission in 1937 that many of these small hospitals had been founded 'upon the mere whim or caprice of some person with money to leave.'⁷ In many cases the donor's generosity had been encouraged by local general practitioners striving to prevent the loss of their patients to some larger centre to which they had no access to treat patients. After the initial endowment, it was often difficult to find funding for long term maintenance. Local communities became saddled with institutions they could ill-afford to support. Some hospitals flourished while others found it impossible to fulfil the obligations they had taken on themselves. The distribution of

⁴ Discussed in Chapter 8.

⁵ B. Abel-Smith, *The Hospitals* (London, 1964), p. 406.

⁶ The *Medical Directory* for 1935 lists 605 voluntary hospitals in the English provinces of which 280 were of 40 beds or less and only 42 of 200 or more.

⁷ *Report of the Voluntary Hospitals Commission* (Sankey Commission), 1937, para. 51.

voluntary hospitals across England and Wales became haphazard. While there was overcrowding in some hospitals there were empty beds in others. Standards tended to be poor as each minor hospital attempted to do the work of a major city general hospital in miniature. Hospitals often wasted money in equipping themselves for procedures they could not or should not attempt.⁸ In some areas hospitals had to compete to survive. It was not unusual for difficult cases to be accepted for treatment by 'specialist' general practitioners without the relevant training or experience.⁹ On other occasions an appropriate specialist was not available since consultants in the English provinces based themselves in the large and prosperous centres of population.¹⁰ The major voluntary hospitals in England's cities and large towns maintained the highest standards of care but in many hospitals across the country standards were at best uncertain.

While the voluntary hospitals in England were supported by endowments and donations, four out of five were also dependent on income from paying patients.¹¹ In the years immediately after the First World War there was a dramatic drop in income from all sources. It was the threatened financial embarrassment of the London teaching hospitals that, in 1921, prompted the Ministry of Health to set up a committee under the chairmanship of Lord Cave to investigate the financial position of all the voluntary hospitals in England and Wales.¹² Over half the voluntary hospitals were found to have deficits on their normal income. Income from gifts and investments had suffered most in the downturn; their contribution to income had fallen from 88% in 1891 to 55% by 1921.¹³ More than ever the voluntary hospitals were forced to rely on income from paying

⁸ Ibid.

⁹ Ibid.

¹⁰ The *Medical Directory* for 1935 lists twelve teaching hospitals with a total of 5,566 beds.

¹¹ Hospitals receiving paying patients in 1935 are indicated in the *Medical Directory*.

¹² *Report of the Ministry of Health Voluntary Hospitals Committee* (Cave Report), HMSO, 1921

¹³ C. Webster, *The Health Services Since The War i* (London, 1988), p. 4.

patients. As an immediate rescue package, the Cave Committee recommended a support grant from Treasury funds of £1 million for 1921, possibly to be repeated in 1922. A further £250,000 was recommended for upgrading and extensions. The recommendations of the Cave Committee were rejected. The government agreed only to a once-and-for-all sum of £500,000 and appointed a commission¹⁴ under the chairmanship of Lord Onslow to manage the allotted fund. The Onslow Commission set up area committees to advise on the local distribution of government moneys and to encourage and organise appeals for additional funds in each local area. However, the local committees soon found that the £500,000 allocated by government as a rescue package was more than adequate.¹⁵ By 1924 it was clear that the Cave Committee had overestimated the problem; the revenue of the voluntary hospitals had not continued to fall as Cave had predicted. However the managers of the voluntary hospitals persuaded the Onslow Commission that, to meet the increasing demand for hospital services, some 10,000 new beds would be required in England and Wales. Government was asked for a special grant to allow this projected deficiency to be made up by the voluntary hospitals. However the Minister of Health, Neville Chamberlain, ruled that any further allocation of Treasury funds was impractical in the existing financial situation.

Since improvement of hospital services could not be achieved by expansion, Onslow hoped that the local area committees already set up by his Commission would be willing to remain in being to co-ordinate a more efficient use of the existing hospital resources in their areas. But few local committees complied. Although attempts at co-ordination among voluntary hospitals were made in a very few major centres,¹⁶ in general, the voluntary hospitals continued to work in competition with each other. The British

¹⁴ *Report on the Voluntary Hospitals Accommodation in England and Wales*, 1925, Cmd. 2486.

¹⁵ J. Pater, *The Making of the National Health Service* (London, 1981), p. 13.

¹⁶ Liverpool, Manchester, Sheffield and Oxford (G. Finlayson, *Citizen, State, and Social Welfare* (Oxford, 1994), p. 240.).

Hospitals Association, formed in 1884 to promote the interests of the voluntary hospitals, was well aware of the dangers of indiscriminate and over ambitious competition. But the Association was not well supported and hospitals were slow to join. As its Secretary commented 'the hospitals consistently closed their eyes to danger patent to all except themselves.'¹⁷ But slowly the provincial voluntary hospitals came to understand that their future was under threat and in 1935 the British Hospitals Association decided that there would be support for a commission

to take into consideration the present position of the voluntary hospitals of the country; to enquire whether in view of the recent legislative and social developments it is desirable that any steps should be taken to promote their interests, develop their policy and safeguard their future, and to frame such recommendations as may be thought expedient and acceptable.¹⁸

While the voluntary hospitals were threatened by competition among themselves there was also an increasing threat from a new hospital system. The Local Government Act of 1929 had launched, in England and Wales, a process of reform of local authority hospitals. The reforms had been long in coming. In 1909 the Minority Report of the Royal Commission on the Poor Laws and Relief of Distress had condemned the hospital services provided under the Poor Law as a grave public scandal. It had recommended the creation of a unified service to be provided by county and county boroughs through their health committees. That recommendation was not followed. In the 1920s, in the *Lancet's* judgement, the Poor Law hospitals were still little better than the rubbish heaps of practice. In 1929 the Local Government Act, in line with the recommendations made 20 years before, concentrated the responsibility for public health and Poor Law medical services in the hands of a single local authority in each county and burgh. The Act also allowed each local authority greater freedom in conducting its own affairs. The system of

¹⁷ Abel-Smith, op.cit., p. 411.

¹⁸ *Report of the Voluntary Hospitals Commission* (Sankey Commission), op.cit., p. 5.

percentage grants, previously given at the discretion of the Minister of Health for each individual local service, was discontinued and replaced by a system of block grants to be used at the discretion of the local authority. Local authorities were urged to use their new powers to improve their services. As a vital component of this improvement, local authorities were invited to submit schemes for the appropriation of Poor Law medical institutions administered by their Public Assistance Committees to allow for their upgrading as general hospitals administered by their Public Health Committees.¹⁹

Although there was a general awareness that hospitals now coming under the control of the new local authorities were less than satisfactory, in 1929 the Ministry of Health had little information on the true extent of the problem. From the autumn of 1930 members of the medical staff of the Ministry conducted a survey of all local government hospital services in England and Wales. Their report was completed in 1935.²⁰

In retrospect the report was unsatisfactory. Over the five years the Ministry failed to set clear standards by which services should be assessed. In 1932 the Ministry decided that it would be inappropriate to determine the number of hospital beds required in each local authority area on the basis of the size of the population to be served but it failed to decide on an alternative.²¹ There was also continuing uncertainty about the standards of patient accommodation to be required of public hospitals. Only in 1933 was a committee appointed under the chairmanship of Sir Amherst Bigge to determine what should be set down for 'the treatment of disease...tak[ing] account of modern methods of construction.'²² This committee had not completed its deliberations in 1935.

For their part the Local Authorities were slow to make use of their new powers.

¹⁹ Technically the Local Government Act allowed for the separation from the Poor Law those services which could be discharged under other enactments such as the Public Health Act 1875, the Maternity and Child Welfare Act 1918, the Public Health (Tuberculosis) Act, 1921 and the Blind Persons Act, 1920.

²⁰ *Annual Report of the Ministry of Health, 1934-35*, Cmd. 4978, p. 97.

²¹ *Annual Report of the Chief Medical Officer, 1932*, p. 168.

²² *Ibid.*, 1933, p. 204.

Improvements were expensive and borrowing required the sanction of the Ministry of Health. In September 1931, Ministry of Health Circular 1222 made it clear that, due to 'the difficulties in the present financial situation' consideration should only be given to schemes for the improvement that was so urgently required 'on grounds of public health.'²³ The financial situation eased later but in 1933-34 borrowing by Local Authorities for hospital improvements allowed by the Ministry was limited to £302,359 reduced for 1934-35 to £275, 701. Income from patients also seemed threatened by the changes in administration. The Poor Law local authorities could be sure that they would receive the appropriate payments from the patients, or from their relatives, for treatment received in hospitals under their administration. But the mechanism for recovering any part of the cost of treatment in hospitals appropriated and administered under the Public Health Acts was far from certain.

Apart from these financial considerations, many County Councils had other reasons for the reluctance to submit schemes for appropriation. As the Chief Medical Officer, Sir George Newman, explained:

The problem consists essentially in converting a number of isolated units intended to serve portions of the county into a system to serve the county as a whole. In some counties the situation is complicated by the reluctance of patients to be moved out of their own area. The institutional care of the sick in the counties also differs somewhat from the county boroughs, as in the rural institutions the number of patients with acute illness is generally small since they are usually sent into Voluntary Hospitals.²⁴

By 1932 only 27 of the 97 boroughs in England and Wales had submitted schemes for the appropriation of Poor Law hospitals and none of the 48 counties.²⁵ Over the next two years further schemes were approved for a further small number of Borough and a

²³ *Annual Report of the Ministry of Health, 1931-32*, Cmd. 4113, p. 46.

²⁴ *Annual Report of the Chief Medical Officer, 1932*, op.cit., p.162.

²⁵ *Ibid.*, p. 162.

very few county schemes.²⁶ In 1935 the Ministry reported on the total number of hospitals and hospital beds in England and Wales now provided under the Public Health Act and those still administered by Public Assistance. In Table 1 these numbers are shown along with the corresponding figures for the hospitals maintained by voluntary organisations.

Table 1.

Hospitals in England and Wales 1934/35

	Local Authority			Voluntary	
	Hospitals			Hospitals	
	No.	Beds		No.	Beds
Public Health	326	57,129	General	663	49,673
Public Assistance	532	86,365	Specialist	325	22,283
Total	858	143,494		988	71,956

Sources: *Annual Report of the Ministry of Health, 1934/35*

Annual Report of the Chief Medical Officer, 1933

These bed numbers give no indication of the standard of medical care delivered by each of the hospital services. The drive for modernisation that was causing necessary expense for the managers of the voluntary hospitals was discouraged by most local authorities; many local authorities had not completely abandoned the mind set of Poor Law administrators. As the *Lancet* pointed out, the municipal hospitals were also at a financial disadvantage in being unable to control admissions of, or to discharge, the chronic sick; they were therefore committed to the continuing expense of their long term care.²⁷ Teaching hospitals also took every opportunity to shed their uninteresting and unprofitable cases to the nearest municipal hospitals. Although the appropriated public hospitals were now directed by medical superintendents rather than by masters they

²⁶ *Annual Report of the Ministry of Health 1934-35*, op.cit., p. 99.

²⁷ *Lancet*, i, 1935, p. 888.

continued to be under-funded and under-staffed; professional standards remained poor. Patients in the Public Health hospitals and their associated clinics were cared for by fewer than 500 full-time doctors with part-time assistance from a further 2,000. This was an impossibly high patient doctor ratio. The quality of medical staff employed was not good. Salaries were low, working conditions were poor and few doctors were unwilling to be 'first and foremost local government officers and doctors only secondarily.'²⁸ Nursing staff was usually inadequate; in many hospitals the ratio was one nurse to 13 patients.²⁹ Poorly motivated by their administrators, understaffed and inadequately equipped, the municipal hospitals did not deliver a good standard of care.

The overall figures published by the Ministry of Health in 1935 did not reveal the great disparities in the distribution of hospital services, voluntary and local authority, which existed across England and Wales. In the west the population of Devon was chiefly served by 34 small voluntary hospitals (average 44 beds) with only one public health hospital of 570 beds.³⁰ On the other hand, in Lancashire in the north there were 14 public health hospitals with a total of 10,975 beds and two Poor Law hospitals giving a further 3285 beds; the voluntary sector provided little more than half (7681) of the general hospital beds in the county dispersed in 37 small hospitals.³¹ In the east, Lincolnshire was served entirely by 14 small voluntary hospitals; Norfolk had no Public Health hospitals but a quarter of the county's general hospital beds were provided by a single Poor Law hospital.

In 1935 the reform of the old Poor Law medical services in England and Wales was very far from complete. Nevertheless the voluntary hospitals were now beginning to rally to the British Hospitals Association to protect their interests against what was now

²⁸ E. Grey-Turner and F. Sutherland, *History of the British Medical Association* (London, 1982), p. 158.

²⁹ *Annual Report of the Chief Medical Officer*, 1932, p. 164.

³⁰ *Medical Directory*, 1935.

³¹ *Ibid.*

perceived as the growing competition and threat from the new local authority general hospitals. Ominously the Chief Medical Officer felt it necessary to urge that there was 'no reasonable cause of war between them.'³²

In London the development of hospital services had a history separate from that of the services in Counties and County Boroughs. London was a special case.³³ Under the provisions of the Act of 1929 the functions of the 25 Metropolitan Boards of Guardians and the Metropolitan Asylums Board³⁴ were transferred to London County Council (LCC). The LCC, which had no previous responsibility for institutions providing in-patient medical care, now became responsible for a total (including infectious disease and mental hospitals) of 76 hospitals and over 42,000 beds.³⁵ Anticipating the provisions of the Act, the LCC had earlier set up a new sub committee of the Public Health Committee (later the Hospitals and Medical Services Committee) to undertake the 'gradual reconstitution'³⁶ of a number of their institutions to create hospitals of sufficient 'status' to offer a general medical and surgical service to the public in London. In 1929 the Ministry of Health accepted that the transformation of the Boards of Guardians' institutional services into a unified municipal hospital service for London would prove difficult due to the extent and complexity of the services involved. However the new Public Health Committee for London was able to appropriate immediately 29 Poor Law hospitals (28,000 beds) and 12 Public Assistance Institutions (9,500 beds) for upgrading. A small number of other institutions (including a former military hospital) were also acquired by the Committee under a separate provision of the 1929 Act. Almost all these appropriated institutions were large, varying in size from 260 to 1,500 beds, and not of

³² Ibid., p. 196.

³³ Ministry of Health reports and all other relevant publications such as the *Medical Register* and the *Medical Directory* deal separately with London and the English and Welsh provinces.

³⁴ The Metropolitan Asylums Board was responsible for fever hospitals

³⁵ *Annual Report of the Ministry of Health*, 1934-35, Cmd. 4978, p.54.

³⁶ Ibid.

the standard that would be expected of a modern voluntary hospital. Many were 'antiquated both in design and equipment. Uniformity of staff was of course necessarily absent.'³⁷ As in the provincial local authority hospitals there were deficiencies in the standards of the nursing staff and doctors were few in number and generally without specialist training.³⁸ The process of upgrading these hospitals would be costly. Nevertheless, and in spite of the national financial stringency between 1931 and 1933, the LCC was able to begin a long-term program of major works together with an annual program of minor upgrading. The bed capacity of the local authority general hospitals was increased and further institutions were appropriated. New wards were created and 11 operating theatres and six X-ray departments were installed. Five hospitals were provided with some form of laboratory service of their own and five group biochemical laboratories and one histological laboratory were set up to serve all LCC hospitals. From 1932, whole-time staff became somewhat better motivated; although still under the direction of a medical superintendent they were allowed clinical responsibility for patients under their care. From 1933 part-time consultants and specialists were appointed on a sessional basis.³⁹ In July 1933 the foundation stone was laid at the LCC's Hammersmith Hospital for a new Post-Graduate Medical School which it was hoped would open in 1935.⁴⁰ In a further effort to lessen the distance between municipal hospitals and mainstream medical practice, it was arranged that Public Health hospitals would be opened to London's teaching hospitals to provide clinical experience for medical students. (Unfortunately the offer was not received with enthusiasm; by 1935 only six students had taken advantage of the arrangement.)⁴¹

³⁷ Ibid., p. 56.

³⁸ The Lambeth Hospital, for example, had 1310 beds all under the direction of a single medical superintendent, who although licensed, was not a graduate and had no higher training or qualification.

³⁹ Consultants received a payment for each session of 2 to 3 hours work at the hospital.

⁴⁰ *Annual Report of the Ministry of Health, 1933-34*, Cmd. 4664, p. 8.

⁴¹ Ibid.

By 1935, although the process of upgrading was far from complete ('completion of the process could not be expected to take place in the short time which has elapsed since the transfer.'⁴²), much had been achieved. The care of the chronic sick was concentrated in 21 hospitals (6882 beds)⁴³ administered under the Poor Law and the LCC could now claim to provide a service for 'acute sick' of London in their 40 Public Health hospitals (21,000 beds).⁴⁴ The service was not yet of high quality. Teaching hospitals still took every opportunity to shed their unwanted cases to the nearest local authority hospitals. (The London Hospital, for example, discharged cases to the old Poor Law hospitals now re-incarnated and renamed St. Peter's, St. Andrew's and St. Leonard's Hospitals.)⁴⁵ Employment by the local authority still did not attract the best medical staff. Understandably Public Health hospitals were not popular with the public. Not only was the standard of care perceived to be poor but also patients were liable to pay for treatment on the basis of a means test, a process most working class people found to be highly objectionable. Nevertheless the service was improving and growing; LCC general hospitals now provided more beds per head of population than the combined resources of the voluntary and Public Health hospitals provided across England and Wales.⁴⁶

In London, hospitals were not only part of a public service, they could also be entrepreneurial businesses and a form of charity. Excluding the great teaching hospitals in 1935 there were 82 small general and special hospitals; 17 were supported entirely as charities; 65 provided services for paying patients.⁴⁷ Although the voluntary hospitals attracted many of their patients from outside London they were nevertheless threatened by

⁴² *Annual Report of the Ministry of Health, 1934-35*, Cmd. 4978, p. 66.

⁴³ *Ibid.*, p. 98.

⁴⁴ *Ibid.*, p. 58.

⁴⁵ A. E. Clark-Kennedy, *The London* (London, 1963), p. 236.

⁴⁶ LCC public hospitals provided 5 beds per thousand of the population of the County of London; the number provided by voluntary and public health hospitals in England and Wales was 3.8.

⁴⁷ *Medical Directory, 1935*

the growth of the LCC's municipal hospitals which were increasing in sophistication and already had almost twice as many beds.⁴⁸ Although under the Local Government Act of 1929 the voluntary hospitals were allowed representation on the local authority committees responsible for development of London's Public Health hospitals in their districts, this was thought to be a sufficient safeguard against encroachment. In 1935 the voluntary hospitals looked to the London Regional Committee of the British Hospitals Association to protect their interests.

The London teaching hospitals were a separate case. They were not part of the LCC hospital service. Neither did they belong comfortably to the company of the small voluntary hospitals in London or in the provinces of England and Wales.⁴⁹ These twelve independent institutions had long histories and distinguished reputations but for a time at the end of the First World War even they were financially unsound. Income had increased since 1913 but operating costs had risen by at least twice as much.⁵⁰ The London Hospital and King's College Hospital were forced to close beds; the Middlesex and St George's could only finance two thirds of their expenditure from income. It was their temporary financial embarrassment that had prompted the Ministry of Health to set up the Cave Committee and they shared in the financial help secured by the Committee. But in the crisis they also sought their own salvation. Patients were required to contribute to their care in accordance with their means and private wards were added. In one year between 1920 and 1921 the contribution of patient's payment to income rose from 10% to 25%. Paying patients were recruited from outside London and by 1931 their charges made up 37% of total income. Each hospital had its own fund raising campaign, usually chaired

⁴⁸ The total number of general, maternity and special beds in England and Wales was 13,000. Ibid.

⁴⁹ Teaching hospitals in nine provincial centres did maintain a marsupial connection with the London teaching hospitals sharing, to some extent, their aspirations and attitudes

⁵⁰ Prince of Wales commented that: 'these hospitals will still have to keep up their income at a figure nearly two and a half times what it was before the end of the war.' H. C. Cameron, *Mr Guy's Hospital* (London, 1954), p. 389; Pater, op. cit., p. 12.

by a member of the aristocracy (e.g. Viscount Connaught at Guy's, Lord Knutsford at the London). Some received large private donations such as Lord Nuffield's gift of a new block at Guy's. By the early 1930s the London teaching hospitals were again prospering. In 1933 the Westminster Hospital abandoned its pre-war plans to move to Wandsworth or Clapham and in 1935 opened a new hospital on its old site close to Harley Street. The Middlesex Hospital rebuilt on its central site at a cost of a million and a half pounds in 1935 and St George's planned to do the same. By the mid 1930s the London teaching hospitals were in good heart and had confirmed their presence 'near the fashionable centres of consulting practice.'⁵¹ Uniquely supported by the City, The King's Fund, the Royal Colleges, the Houses of Lords and with ready access to Ministers, the London teaching hospitals saw no reason to throw in their lot with the voluntary hospitals as a whole.⁵² When a committee (London Voluntary Hospitals Committee) was set up at the prompting of the King Edward's Hospital Fund for London to represent the interests of all the voluntary hospitals, the teaching hospitals insisted on their own special representation through the Conference of Teaching Hospitals.

By 1935 the teaching hospitals, the other voluntary hospitals and the LCC were all prospering to a degree not shared in the provinces. But all recognised that change was inevitable, but there was no coming together of minds. As Pater, at the time an official at the Ministry of Health and an 'insider' witness to events, has recorded, between the voluntary hospitals and the local authorities 'the climate was not so much that of co-operation as of cold war.'⁵³

This uncertain progress towards an efficient hospital service for England and Wales was soon to be disrupted by preparations for war. But by then the Ministry of Health had come to its own view of the way forward. Before his death in 1920, Sir Robert

⁵¹ Abel-Smith, *op. cit.*, p. 408.

⁵² *Ibid.*, p. 411.

⁵³ Pater, *op.cit.*, p. 16.

Morant, the Ministry's first Permanent Secretary had prepared a memorandum⁵⁴ setting out a plan for the future. In Morant's plan, conceived when the voluntary hospitals were in financial difficulty, it was assumed that voluntary hospitals were doomed and that all future hospital provision would inevitably be in the hands of the county and county borough councils, acting through health committees composed in part by co-opted experts. By 1935 circumstances had changed and this plan had been abandoned. The Ministry of Health now accepted that 'co-operation between the local authorities and the governing bodies and medical staff of voluntary hospitals⁵⁵ is not merely a desideratum but an imperative need, and this is likely to continue in increasing degree in the future.'⁵⁶ It was proposed that local authorities should accept responsibility for the hospital treatment of all infectious diseases (including tuberculosis), for maternity, for children, for 'lunacy' and for the treatment of the necessitous. However, it was proposed that local authorities should be permitted to discharge these responsibilities, in whole or in part, by contracting them out to voluntary hospitals. This was to be the normal practice where treatment involved 'expensive materials, particular apparatus or highly specialised skills.'⁵⁷ For the Ministry, Sir George Newman advised that local authorities should not attempt to duplicate all the facilities available in voluntary hospitals. Since it was accepted that voluntary hospitals would not be in a position to provide for all acute cases, it was advised that Local authorities should make provision for similar cases to those treated in voluntary hospitals but only where this was not to 'engage in wasteful competition.'⁵⁸

⁵⁴ PRO MH 80/24.

⁵⁵ In Morant's scheme influential medical input to management was to be through 'experts' on local health committees. The Chief Medical Officer suggested that doctors should have a major part in the administration of their own hospitals.

⁵⁶ *Annual Report of the Chief Medical Officer*, 1933, p.193.

⁵⁷ *Ibid.*, p.198.

⁵⁸ *Ibid.*, p.196.

In 1935 there were five distinct groupings – the London teaching hospitals, all other voluntary hospitals in England and Wales, the London County Council hospitals, the provincial local authority hospitals and the Ministry of Health – each with its own interests and its own view of the way forward. There was no consensus in sight.

Hospitals in Scotland

In Scotland the situation was quite different. By the 1930s the various bodies supporting and serving the hospital services had already established a habit of co-operation. The Cathcart Committee could confidently plan to build on much that had already been agreed.

Historically, in Scotland the state had made little provision for the institutional care of the sick poor. In 1919 the few poor houses that had been built since the middle of the nineteenth century came under the administration of the Scottish Board of Health.⁵⁹ The Board soon ‘had under consideration the whole question of the accommodation in poor law institutions’.⁶⁰ Some older buildings were found ‘unsuited to modern requirements’ and were sold. Plans were made to transfer inmates out of some larger poorhouses to allow the buildings to be adapted for use as hospitals for infectious disease,

⁵⁹ In 1850 there were 21 poor houses (6058 beds) in Scotland. By 1900 the number had increased to 65. *Report of the Royal Commission on the Poor Laws and the Relief of Distress in Scotland*, 1909, Cd. 4922, p. 855.

⁶⁰ *Annual Report of the Scottish Board of Health*, 1920, Cmd. 1319, p. 236. The efforts of the Scottish Board of Health to make better provision for the poor were aided by the Poor Law Emergency Provision (Scotland) Act of 1921 which as a temporary measure allowed parish councils to grant relief to the able bodied poor. This power was continued annually by Expiring Laws Continuation Act until confirmed by the Poor Law (Scotland) Act of 1934. Between 1914 and 1934 the number entitled to aid under the Poor Laws quadrupled.

for mental defectives or for convalescent patients. In Glasgow, the Govan Poorhouse was adapted to become the Southern General Hospital, a Poor Law hospital operating as a general hospital alongside the city's three existing purpose-built Poor Law hospitals.⁶¹ Consultants – physician, surgeon, obstetrician, paediatrician, psychiatrist, ophthalmologist, ENT surgeon, and dermatologist – were appointed to bring the Poor Law hospitals in Glasgow to 'a standard equal to the best general hospital.'⁶² A working association was established in Edinburgh between the voluntary and the poor law hospitals in the academic year 1919-20 when clinical teaching of medical students was introduced in the Poor Law institutions. In 1920 the Medical Research Committee (forerunner of the Medical Research Council) set up a unit in Edinburgh, at Craiglockart Poorhouse Hospital, to work on infant nutrition. In 1928 the Town Council of Aberdeen had already assigned the town's Poor Law hospital as a municipal general hospital in the Northeast Regional Hospital scheme. This co-operative scheme had been founded in 1925 by the Aberdeen County Council, Aberdeen County Education Authority, Aberdeen Royal Infirmary and the medical faculty of Aberdeen University to ensure that the most effective use was made of the medical services in the north-east.⁶³

To an extent the Scottish Board of Health had anticipated the Local Government (Scotland) Act of 1929. Its successor, the Department of Health for Scotland continued the reform of hospital service along the lines already set by the Board. The Department continued to insist that wherever hospital developments or reorganisations were being planned by a local authority, the local voluntary hospitals must be consulted. 'As a result of this policy, the relations with the managing bodies of the voluntary hospitals have

⁶¹ Stobhill Hospital, Eastern District Hospital (Duke Street) and Western District Hospital (Oakbank).

⁶² *Annual Report of the Scottish Board of Health*, 1923, Cmd. 2156, p. 172. The first appointments were made to Stobhill Hospital in 1923.

⁶³ *Annual Reports of the Scottish Board of Health*.

become increasingly intimate and friendly.’⁶⁴ It was found that much of the reorganisation and extension could continue without recourse to the provisions of the 1929 Act.⁶⁵ Glasgow Corporation continued to administer and upgrade its hospitals. Responsibility for medical care in Glasgow’s Poor Law hospitals was delegated to the Public Health Committee but continued as a charge against the Poor Law.⁶⁶ The success of the program to ‘seed’ these hospitals with consultants from the teaching hospitals was later recognised by the establishment of the Chair of Materia Medica at Stobhill Hospital in 1937. Reform was already in progress across Scotland under existing legislation and only the local authorities of Edinburgh, Dundee, Aberdeen and Bute chose to use the provisions of the Act of 1929 to appropriate Poor Law accommodation for general hospital use. In Edinburgh three Poor Law institutions were appropriated to become the Western General Hospital, the Northern General Hospital and the Eastern General Hospital; in 1932 the clinical professors of the Edinburgh University were appointed as clinical directors and university staff were appointed for clinical and teaching duties in these hospitals. Maryfield Hospital was appropriated and upgraded in Dundee. In Aberdeen, Woodend Hospital was formally appropriated as a Public Health hospital but still as part of the Northeast Regional Hospital scheme. In Bute, part of the Lady Margaret Hospital for infectious disease was appropriated for use as general medical and surgical wards.⁶⁷

In 1934 the Department of Health completed a survey of hospital accommodation in Scotland. In all there were 449 hospitals and a total of 31,250 beds.⁶⁸ Of these 179 (11,520 beds) were special hospitals for those patients – infectious disease, maternity,

⁶⁴ *Annual Report of the Scottish Board of Health*, 1923, Cmd. 2156, p. 172.

⁶⁵ *Ibid.*, 1931, Cmd. 4080, p. 80.

⁶⁶ *Ibid.*, 1930, Cmd. 3860, p. 158.

⁶⁷ *Annual Reports of the Department of Health for Scotland*

⁶⁸ This did not include institutions for certified lunatics and mental defectives but did include Poor Law institutions with beds for the sick poor.

paediatric, orthopaedic – for whom the local authorities had a statutory duty of care under the Public Health (Scotland) Act of 1897, the Maternity and Child Welfare Act of 1918 and the Local Government (Scotland) Act of 1929. Still under the Poor Law, 55 mixed poor houses provided 3270 beds. In all, the local authorities administered nine general hospitals (3,880 beds) - four in Glasgow still technically administered under the Poor Law and a total of five in Edinburgh, Dundee and Aberdeen under the Public Health Acts. By 1934 all of these general hospitals had well established associations with their local medical schools and were being assisted by members of their clinical staffs.⁶⁹

The Scottish Board of Health and the Department of Health for Scotland had increased the number of general hospitals administered by the local authorities and had presided over an improvement in their standards of care. However, in 1935 most general hospital services⁷⁰ in Scotland were still provided by 206 (12,575 beds) voluntary hospitals.⁷¹ In the main centres the larger voluntary hospitals were also the teaching hospitals of the university medical schools. Scotland's voluntary hospitals had grown up over more than two centuries, established and maintained by their local communities. As a result the distribution of hospitals and hospital beds in Scotland corresponded closely with the distribution of the people. Some 65% of voluntary hospital beds were in large hospitals, each with an average of 707 beds, in the four major cities. Some 22% of voluntary hospital beds were in the county towns and other large burghs in hospitals with bed capacities between 100 and 250. Six smaller burghs had their own hospitals with between 40 and 80 beds. The remaining 8% of Scotland's beds were scattered in small cottage hospitals of 6 to 30 beds in the most rural parts of the country.⁷²

⁶⁹ *Annual Reports of the Department of Health for Scotland.*

⁷⁰ General medicine and surgery but excluding the new specialities, e.g. neurosurgery and plastic surgery.

⁷¹ Most beds were used by surgical services. Some 500 beds were allocated to maternity cases. The allocation of medical beds fluctuated according to circumstances.

⁷² *Medical Directory*, 1935.

Scotland had no teaching hospitals as separate and independent institutions on the model of the London teaching hospitals. From their beginning, the medical faculties of Scotland's universities had relied for their clinical teaching on the great voluntary hospitals of the cities in which they were based. Scotland's hospitals came to fall naturally into a regional pattern. Four regions centred on the four great cities and their medical schools; the fifth was the more remote and diffuse region centred on Inverness, with Royal Northern Infirmary as its central hospital but dependent for the most specialised services on the university centres. In 1923 the Scottish Board of Health had recommended that these regional formations should be formally recognised with committees appointed to co-ordinate the activities and development of all hospitals, voluntary and local authority, within each region.⁷³ This recommendation was not accepted and no statutory structure was put in place. But functional alignments continued to develop. Although unofficial, these alignments were well founded not only as pragmatic arrangements within recognised geographic areas but also on the personal relationships that were to be expected where the great majority of the medical profession in each area were graduates of the local medical school. It became the practice of the Scottish Board of Health and its successor, the Department of Health for Scotland, to recognise these groupings as functioning entities; in its Annual Reports the Department of Health adopted the practice of listing all hospitals by Region (Northern, North-Eastern, Eastern, South-Eastern and Western).⁷⁴ The value of these regional groupings between voluntary and local authority hospitals was recognised by government in 1924. The Ministry of Health proposed that an inquiry to be conducted by the Voluntary Hospitals Commission in England and Wales should be extended to include the voluntary hospitals in Scotland. The Scottish Board of Health rejected this proposal since, in its view, limiting the inquiry to voluntary hospitals would prejudice its usefulness in Scotland and

⁷³ NAS HH 65/549.

⁷⁴ e.g. *Annual Report of the Department of Health for Scotland*, 1934, Cmd. 4837.

would be contrary to Scottish practice.⁷⁵ This was accepted by government and in May 1924 the Hospital Services (Scotland) Committee was set up under the chairmanship of Lord Mackenzie to review all hospital services in Scotland both local authority and voluntary.

The Mackenzie Committee remarked on the phenomenal increase in the demand for hospital treatment, especially for surgery, since the beginning of the century.⁷⁶ The Committee found that in 1926 Scotland's hospitals were over-stretched: it was estimated that an additional 3,600 beds were required. The Committee recommended that the voluntary hospitals should increase their capacity by 3000 beds, financed half by the hospitals themselves and half by Treasury funds. It also recommended that local authorities should increase the number of beds for maternity and paediatrics (for which they had some statutory responsibility) by 600, again with support from central government. Mackenzie regretted that the Poor Laws hospitals contributed so little and, anticipating the Local Government (Scotland) Act of 1929, suggested that they should be transferred to the administration of the local authorities, not only to provide patient care but to take a full part in medical teaching and research.

Scotland's hospitals were reviewed again in 1933 by the Consultative Council on Medical and Allied Services under the Chairmanship of Sir Norman Walker.⁷⁷ Walker brought together the recommendations of the Scottish Board of Health in 1923 and the MacKenzie Committee in 1926 and took their proposals to a further stage. Walker again recommended that the regional arrangements in Scotland should be formally recognised and that there should be a single hospital system in each region co-ordinated by a body representing each region's voluntary hospitals, local authority hospitals and medical schools. Walker stressed that such an arrangement could only succeed if there was

⁷⁵ NAS HH 65/50.

⁷⁶ *Report of the Hospital Services Committee* (Mackenzie Report) 1926.

⁷⁷ *Report on Hospital Services*, (Walker Report) 1933.

equality in the equipping and staffing of Scotland's hospitals and uniformity in payment of staff and charges made to patients. While the Walker Report did not lead immediately to any administrative or legislative action, its principles were accepted by the Department of Health and adopted as the basis for its future policy.⁷⁸

In 1935 Scotland's voluntary hospitals continued to be over stretched. The problem is illustrated by the experience of Edinburgh Royal Infirmary, Scotland's largest voluntary hospital.⁷⁹ Like other voluntary hospitals the Infirmary was operating at a deficit which had to be made good from investment income. Over ten years, ordinary income had increased from £1107,200 to £128,649 (20%).⁸⁰ The cost of each inpatient had increased only from £7 10s to £7 18s (5%). However the annual number of inpatients had increased from 17,024 to 20,695 (22%) and the number of out patients had increased even more. Waiting lists had increased from 2,261 to almost 3,500. The financial difficulties of the Edinburgh Royal Infirmary, and the voluntary hospitals generally in Scotland, was not due to the rise in cost of modern medical treatment as has often been claimed. An increase in cost of treatment of only 5% could easily have been accommodated by a rise in income of 20%. The essential problem was the increasing demand for hospital services, not only for in-patient care but even more for consultant advice at out-patient clinics and still more for emergency treatment or minor surgery in the casualty department.

The increase in demand for hospital treatment had been first created in the second half of the nineteenth century by the new effectiveness of surgery improved by anaesthesia and antiseptic and aseptic surgery. Into the twentieth century the demand for beds in hospitals continued to be vastly greater for surgery than for medical treatment. As surgical procedures become more sophisticated fewer could be performed in the patient's

⁷⁸ *Annual Report of the Department of Health for Scotland*, 1934, Cmd. 4837, p. 93.

⁷⁹ LHB/4/122-138.

⁸⁰ Income had fallen temporarily in 1929 and again in 1932-34. *Ibid.*

home (traditionally on the kitchen table). Patients and doctors alike looked more and more to the voluntary hospitals for all but the most minor surgical treatment. The operation of the National Health Insurance Scheme increased the load on hospital surgical services still further. Cases that might benefit from surgical treatment were discovered in increasing numbers as the insured population gained greater access to general practitioners. Even minor operations, which could have been competently performed in the patient's home by his own doctor, were not chargeable against the Insurance scheme. Cases were therefore increasingly referred to the nearest voluntary hospital where treatment was free. The increased demand for surgery did not only come from the insured population. The NHI Scheme brought general practitioners more into contact with the families of the insured leading to the discovery of more problems to be referred for free hospital treatment; in the 1930s up to 44% of patients on the waiting list of Edinburgh Royal Infirmary were children awaiting removal of tonsils and adenoids.⁸¹

Voluntary hospitals in Scotland were prohibited by their charters or instrument of creation from recovering even part of the cost of treatment directly from their patients.⁸² In 1935 Edinburgh Royal Infirmary and voluntary hospitals generally in Scotland were recovering from the lean years of the depression although more slowly than voluntary hospitals in England and Wales. While income from legacies, donations and subscriptions increased well in line with increases in England and Wales the increasing volume of free treatment was a drain on financial resources. In England and Wales, where the great majority derived income directly from paying patients, voluntary hospitals benefited financially rather than suffered from the increasing demand for hospital care. Nevertheless, in spite of this disadvantage the Scottish Committee of the British Hospitals

⁸¹ LHB/4/124.

⁸² 'In general the voluntary hospitals [in Scotland] have no power of recovering the costs of maintenance and treatment. Some are debarred by their charters or other instruments of creation from claiming any payment or are restricted to treating only the necessitous poor.' DH 8/1101.

Association was able to join in the satisfaction of the main body of the Association when it reported that although the annual expenditure of the voluntary hospitals in Britain had increased to £15,000,000, income had increased to £16,000,000 and that over the previous five years £2,500,000 had been invested in new buildings. Sir John Fraser⁸³ was able to report that over the previous ten years the bed complement of Edinburgh Royal Infirmary had been increased by 16.9%. However the waiting list had increased by 71.4% over the same period.⁸⁴ Sir John asserted that the 'opening up of the municipal hospitals' after 1929 had not helped to relieve the burden of an ever-increasing demand for hospital services. (Over a number of years Sir John had drawn particular attention to the new and increasing burden of casualties from traffic accidents; the cost of their treatment was only rarely recovered from the insurance companies.) The Board of Managers of the Infirmary agreed with the British Hospitals Association that 'the Approved Societies had not recognised in a practical way to any considerable extent the services which the hospitals rendered to their members.'⁸⁵ The Chairman of the Board of Managers admitted that the increasing activities of the Infirmary was 'straining the financial resources to the utmost.'⁸⁶ Edinburgh Royal Infirmary's situation in the 1930s was not unique. It was shared by the other voluntary hospitals in Scotland.⁸⁷ In 1936 the British Hospitals Association welcomed the proposal in the Cathcart Report that the voluntary hospitals in Scotland should increase their bed capacity by 3,000 supported by a Treasury grant of £900,000.⁸⁸

⁸³ Professor of Surgery and a manager of Edinburgh Royal Infirmary.

⁸⁴ BMJ, ii, 1936

⁸⁵ LHB 1/60/1.

⁸⁶ LHB/1/70/29

⁸⁷ Histories of other voluntary hospitals in other parts of Scotland record the same situation e.g. D. Dow, *Paisley Hospitals* (Glasgow, 1986) and T. C. Mackenzie, *The Story of a Scottish Voluntary Hospital* (Inverness, 1946)

⁸⁸ BMJ, i, 1936, p. 42.

In spite of increasing financial pressure the voluntary hospitals in Scotland were in no immediate danger of becoming insolvent and looked to increased support from new public appeals.⁸⁹ In 1935 local authority hospitals were not in a position to provide the necessary supplement to the overstretched services in the voluntary hospitals. Patients in the former Poor Law hospitals were being required to pay for treatment as determined by a means test. This together with the social stigma still attached to hospitals that had not yet thrown off the image of the Poor Law made admission to local authority general hospitals very unattractive to patients. General practitioners were also well aware that, although local authority hospitals had improved in the few years since appropriation, they could not yet pretend to the standards of care, particularly surgical care, available in the large voluntary hospitals. Nevertheless, the Department of Health was confident that the hospitals that had been removed from the Poor Law would continue to improve 'as opportunity arises and would in time become an equal partner with the voluntary hospitals in a co-operative hospital services for Scotland.'⁹⁰

The Department therefore regretted that, overall, the reorganisation of local authority hospital services since the Act of 1929 had been 'slow and, on the whole, disappointing.'⁹¹ 'Years of financial stringency have left authorities generally with some arrears of hospital provision.' Reorganisation had been 'a slow business, often involving protracted negotiations between several authorities with conflicting interests and, it may be, long standing antipathies.'⁹² There were still 3270 hospital beds in mixed poorhouses 'long out of date, and in most of them the lighting, the heating and ventilation arrangements are not adapted to hospital requirements. Few of them have proper

⁸⁹ *The Scotsman*, 5 May 1938 and 31 December 1938.

⁹⁰ *Annual Report of the Department of Health for Scotland*, 1934, op.cit., p. 94.

⁹¹ *Ibid.*, p. 97.

⁹² *Ibid.*, p. 95.

operating facilities and the number of resident medical staff is less – often very much less – than in other institutions for the sick.⁹³

The Department of Health was very clear and forceful in its comments on future progress:

A rational reorganisation demands, first, a survey by each local authority of its hospital needs and of the resources it possesses or can utilise; second, collaboration with neighbouring authorities and with managers of local voluntary hospitals in drawing up a long term plan of development; and, third, consideration of each hospital need, as it arises, with reference to the determined plan. If a hospital service at once efficient and economical is ever to be built up in Scotland, local authorities will have to bring themselves, sooner or later, to planning ahead; to considering with their neighbours how wasteful duplication and overlapping can be avoided; and generally, to securing that every step they take, however small, will contribute to an effective service not merely for themselves but for the hospital region of which they are a part.⁹⁴

In spite of the slow progress being made by the local authorities the Department of Health for Scotland remained confident that the policies set by the Scottish Board of Health, developed in the Mackenzie Report and the Walker Report, would eventually prove successful. The Cathcart Committee did not propose any break from these policies nor did it consider it necessary to conduct yet another review of hospital services; the Committee accepted that the ‘central problem is the inadequacy of hospital facilities.’⁹⁵ As measure of the inadequacy Cathcart referred, not to the number of beds in relation to the numbers of the population, but to the unanimous reports from general practitioners of their difficulties in arranging admission for their patients. Delay for acute cases was negligible but there were unacceptable delays in medical admissions for diagnosis and treatment and even greater delays for surgery. On average the delay for ENT surgery was

⁹³ Ibid., p. 94.

⁹⁴ Ibid., p. 97.

⁹⁵ Cathcart Report, p. 233.

70.1 days, for hydrocele and varicocele, 62 days, for hernias 37 days, for gynaecology 35.5 days, for non-malignant tumours 29.3 days, for haemorrhoids 23.3 days, for gastric and duodenal ulcers 20 days.⁹⁶ Cathcart endorsed the policy advocated by the Department of Health and supported by the representatives of the voluntary hospitals,⁹⁷ that it should fall to the local authorities to fill the gaps in the existing hospital services. In Cathcart's judgement the delay in achieving the co-operative hospital service planned for Scotland was mainly due to the 'financial difficulties' of the local authorities.⁹⁸

Cathcart recognised that the voluntary hospitals performed a great public service, had a fine tradition and enjoyed the confidence of the people. It was therefore in the interests of the state to avoid any action that would weaken their position. To ask them to meet the existing shortfall by increasing their bed capacity, even with the support of a capital grant from Treasury funds, would, in the long term, impose on them a serious burden of maintenance that they might not be able to carry indefinitely. In view of their particular dependence on legacies and donations, Cathcart proposed that the position of the voluntary hospitals should be eased by granting them immunity from legacy and succession duties and remission from local rates. It was also thought that they should receive a grant in support of their teaching facilities; this would be appropriate and would cost the state very little.

Cathcart also recommended that the Department of Health should be given powers to require, rather than to encourage, local authorities to bring their hospitals up to a standard that would allow them to take their full part in co-operative hospital service for Scotland in which one group of hospitals would not 'be regarded as inferior to the other

⁹⁶ Cathcart's comment has resonance today- 'The shortage has continued for a long time and it may be that in some quarters there is a tendency to get used to it.' Cathcart Report, p. 234.

⁹⁷ Cathcart Report, p. 240.

⁹⁸ *Ibid.*, p. 235.

and all the hospitals should be administered in the same spirit and should aim at the same standards.⁹⁹

In short, the hospitals of all kinds, whether they are general or are limited to a specialism, whether they are managed by a statutory body or by a voluntary board of management, must be viewed as a whole and over wide regions; that must be regarded as one service. This conclusion is now commonplace; it is stated in much of the evidence submitted to us. To execute a policy based upon it, however, some adjustments of law and of administration are necessary.¹⁰⁰

The Committee agreed that an effective system of central supervision must be established. Something more was required than the existing statutory obligation on local authorities to 'take account of' the voluntary hospitals in any reorganisation or extension of their services. The Committee therefore adopted the proposal, made by the representatives of the teaching hospitals in Glasgow, that the voluntary hospitals in Scotland should be officially recognised by the state as an essential component of the country's health services and that as a corollary they should accept the supervision and guidance of the Department of Health for Scotland.¹⁰¹ The Committee proposed that regional hospital service committees, representing voluntary and statutory hospitals, should be set up by statute for each of the five regions in Scotland. These were to be advisory bodies to facilitate co-operation within the regions; all developments recommended by these regional committees were to be submitted to the Department for approval. The Department, in its turn, must maintain a close relationship with the regional committees. For co-operation between statutory and voluntary hospitals it was necessary to place both groups of hospitals on an equal footing. All hospital services were

⁹⁹ Cathcart Report, p. 243.

¹⁰⁰ Ibid., p. 237.

¹⁰¹ Ibid., p. 239.

to be regarded as a public health function and completely dissociated from the Poor Law. No hospitals were to remain in the control of the Poor Law authorities.¹⁰²

The Cathcart Report drew attention to the differences imposed by history on the development of hospital services in Scotland and in England and Wales. The historic reluctance of the state in Scotland to provide for the institutional care of the sick poor had imposed on the voluntary hospitals the civic duty to care for the poor and to give greater emphasis to their charitable functions. It had never been intended, or even made possible, that the voluntary hospitals in Scotland should exploit any opportunity for entrepreneurial success. This was one of the major distinctive characters of medical provision in Scotland which, in 1919, were accepted as justification for separate administration of medical services. When the Ministry of Health was set up to administer services in England and Wales, a Scottish Board of Health of six members, none a civil servant, was appointed to be responsible for the 'co-ordination of measures conducive to the health of the people.'¹⁰³ The Board had adopted a pragmatic approach to securing an effective service for the community, accepting that the desired results could best be achieved by consensus and by nurturing every possible resource. The Ministry of Health on the other hand, under the domination of its first Secretary, Sir Robert Morant, was more ideological.¹⁰⁴ Morant proposed that the government should do nothing to halt what seemed, in the years immediately after the First World War, to be the inevitable demise of the voluntary sector, while with the support of central government, hospital services became entirely the province of local government. By the 1930s the Ministry, advised by its Chief Medical Officer, Sir George Newman, had reversed its policy. The voluntary hospitals had not continued to decline as forecast. There had been no need for the assistance proposed by Lord Cave in 1921. For the Ministry of Health Newman now

¹⁰² Cathcart Report, p. 248.

¹⁰³ NAS HH/1/467.

¹⁰⁴ Morant was a friend of the Webbs and Fabian in his outlook, but the Fabian Society has no record that he was ever a member.

envisaged a two-tier system; voluntary hospitals were to be encouraged to continue to establish their position as the leaders in providing the best of modern equipment and the highest levels of expertise.¹⁰⁵ However 'the voluntary hospitals are not in a position to provide for all acute cases and the local authority is therefore compelled to make provision for similar cases to those treated by the voluntary hospitals.'¹⁰⁶ The views of the Ministry in the 1920s and again in the 1930s were widely known and were contentious. The British Voluntary Hospitals Association was suspicious of any encroachment of local authority hospitals on the services of their members in acute medicine and surgery. London County Council, now well on the way to creating a large, modern and sophisticated hospital service, resented the suggestion that the highest levels of service should be the prerogative of the voluntary hospitals. Most provincial county councils, on the other hand, were in no position to provide even the second grade hospitals in the numbers proposed by the Ministry. The London teaching hospitals were unwilling to abandon any of their independence, their privileges or their unique financial resources. In England powerful forces were gathering and conflict was inevitable. As the discord continued and became more bitter in the 1940s it did not spread to Scotland. In Scotland history had not created the divisions or the powerful factions that existed in England. Over the years a consensus had developed in Scotland and that consensus found its expression in the Cathcart Report. As will be discussed in Chapter 8, the Cathcart Report was not only important for Scotland but also pointed the way to a solution of the conflicts in England.

¹⁰⁵ *Annual Report of the Chief Medical Officer*, 1933, p.198.

¹⁰⁶ *Ibid.* p. 196.

CHAPTER EIGHT

GENERAL PRACTITIONER SERVICES

The general practitioner was to be at the heart of the Cathcart Committee's scheme for the promotion of health in Scotland. The state was to be responsible primarily for the creation of social conditions and an environment that would promote rather than destroy health and to provide medical care through an efficient hospital service and specialist public clinics for all those whose health had failed. In Cathcart's scheme the role of the general practitioner (GP) would be as advisor to patients persuaded by a state programme of education to take full charge of the promotion and maintenance of their own health. The general practitioner was also to act as guide to his patients when ill, assisting them in taking advantage of the full range of available medical services. No longer was the general practitioner to confine his role to the management of the day to day failures in health of those in a position to consult him. For Cathcart's health policy to succeed it was essential that the new general practitioner services should be freely accessible to every member of the public.

In the 1930s the services of a general practitioner were beyond the financial reach of a great many people. This was not only a major problem in itself but also contributed to the failure of the local authority medical services. 'The statutory services...presupposed that the persons concerned have the services of a general practitioner.'¹ But the families most in need of assistance were generally the same families that could not afford the services of a general practitioner. The Cathcart Committee found that the advice given by the staff of the local authority services was

¹ Cathcart Report, p. 158.

often futile, sometimes because it was ignored, but usually because of the unaffordable cost of finding a doctor to administer the appropriate medical treatment.

When the Cathcart Committee was convened the National Insurance Scheme made the services of a general practitioner available to only 40% of the population. In the industrial districts some employers, particularly in the mining industry and public works, arranged for deductions to be made from the wages of their employees to provide medical treatment for their dependants. In most areas GPs also organised their own schemes of 'Public Medical Service' in which regular weekly payments secured treatment for those who were not otherwise insured.² Those who had lost or had never had medical benefit could, in theory, resort to the Poor Law for medical attention. In practice most of those who were poor and without medical benefit either received treatment from a general practitioner without payment or did not call a doctor except in extreme circumstances.

It had long been recognised that this fragmented and unsatisfactory arrangement should not be allowed to continue. In 1924 a Royal Commission was set up 'to inquire into the scheme of national health insurance established by the National Insurance Acts, 1911-1922 and to report what changes, if any, should be made in regard to the scope of that scheme and the administrative, financial, and medical arrangements set up under it.'³ The Royal Commission agreed that whatever changes were to be made in the insurance system in the future, the general trend should be towards the development of a unified health service. The Royal Commission did not feel that it was within its remit to set out a policy for the medical services of the future but made it clear that, in its view, the principle of unification must be accepted. In February 1926 it proposed only some very modest changes, 'confining itself to the nuts and bolts of insurance practice.'⁴ The

² A general practitioner scheme set up in Airdrie in 1933 was typical. Medical attendance, treatment and drugs were provided for a weekly fee of 6d. *Glasgow Medical Journal*, cxix, 1933, p. 61.

³ *Report of the Royal Commission on National Health Insurance*, 1926, Cmd. 2596.

⁴ *BMJ*, i, 1926, p. 491 and p. 103

deficiencies of the general practitioner service continued. A large proportion of the 60% not covered by the NHI scheme were unable to pay for medical treatment from their own resources. This resulted, not only in the failure to relieve distress and to prevent unnecessary death, it also left many disorders quiescent rather than cured. Since many of the untreated were children, the failures of the medical service created an accumulating store of ill-health and disability in the adult population.

The absence of general practitioner support had its effect on the efficiency of the statutory medical services. Although Child Welfare Centres were not, and were never intended to be, clinics for sick children, patients were often brought to them inappropriately. Defects discovered at medical inspections by the School Medical Service were notified to the parents, in the expectation that they would arrange for treatment by a general practitioner; in the absence of affordable GP services many children did not receive the treatment prescribed.⁵ The infectious disease hospitals also suffered; patients were often admitted at a late, even terminal, stage of illness as a result of a reluctance to call a doctor; other cases that might have been managed at home were admitted only because of the patients' inability to pay for a general practitioner. The effectiveness of the Tuberculosis Service was reduced; a large number of patients went untreated because they were unable to retain the services of a general practitioner for the whole period of what was almost inevitably a long illness.

In response to these inadequacies of the general practitioner service, some local authorities began to expand their own services. Maternity and Child Welfare schemes, originally intended for mother and children under one year, were extending to include children up to the age of five or more and advice was accompanied by elementary treatment. The School Medical Service, which was required to provide treatment only for the 'necessitous,' began to give a wider interpretation to 'necessitous' and there was

⁵ *Annual Report of the Scottish Board of Health*, 1924, Cmd. 2416.

increasing pressure for the School Medical Service to join hands with the Maternity and Child Welfare Services. Services provided under the Poor Law were also increased as the interpretation of 'destitute' was allowed to become more generous.

In 1932 the situation was exacerbated by the new National Insurance Act. In Scotland the Act deprived some 35,000 people who had been unemployed for long spells of their entitlement to medical benefit. Together with their families these long-term unemployed now increased the pool of people unable to pay for medical treatment. In Glasgow alone the number of able-bodied unemployed and their dependants entitled to Poor Law medical services rose from 20,000 to 96,000.⁶ Many, almost certainly the great majority, were unwilling to accept the stigma of pauperism and to resort to free treatment under the Poor Law. Some found that their 'panel' doctors were willing to continue to provide treatment even after payment for their services from the NHI scheme had been withdrawn. But large numbers turned to the outpatient departments of the voluntary hospitals, putting intolerable pressure on their services. Local authority clinics came under pressure to provide treatments well beyond their proper responsibilities.⁷ More patients with infectious disease could not afford treatment at home, creating a bed crisis in the hospital service.

In 1933 Sir Alexander Macgregor, the Medical Officer of Health in Glasgow, and Glasgow Corporation felt compelled to make special arrangements to meet what had become a crisis. A whole-time service of doctors and nurses was set up to operate from clinics in the 'industrial' districts of the city, to provide free care for those poor who were unable to pay for treatment but were not officially on the Poor Roll. The medical staff was composed almost entirely of Glasgow general practitioners who already had some

⁶ A. Macgregor, *Public Health in Glasgow 1905-1946* (Edinburgh, 1967), p. 144.

⁷ At a conference on the Public Health Services, Alfred Cox, later the secretary of the BMA, gave a paper on 'The Encroachment on Private Practice'. He claimed that the local authority clinics and the hospitals were being abused and that the work could be done by general practitioners at less cost to the public purse. *Lancet*, ii, 1935, p. 1479.

form of part-time appointment with the local authority but were willing to become full-time medical officers for the duration of the crisis.⁸ At its peak this services achieved 72,000 domiciliary visits and 302,000 clinic consultations in a year.⁹ This service was unique and beyond the means of other local authorities. In Scotland generally the distress of the 1930s had greatly increased the number of those for whom, for financial reasons, the service of a general practitioner were simply not available.

A New Role for the General Practitioner

The MacAlister Report¹⁰ had already concluded in 1920 that the change from a 'system that dealt with aggregates and their hygienic environment' to a 'system that includes the medical care and treatment of individuals' that had begun in the early years of the century had not proceeded in any single or well ordered plan. MacAlister advised that Scotland should, indeed must, have a general practitioner service available to all the family rather than only to the breadwinner.

After more than a decade no action had taken place on MacAlister's recommendations. In 1931 the Department of Health again drew attention to the lack of co-ordination in the health services and particularly to the 'difficult problem of co-operation of the private general practitioners in the statutory health services.'¹¹ The Department of Health convened a meeting with representatives of the local authorities, the Scottish Committee of the BMA inviting them to set up a small committee to 'pursue

⁸ In 1938 the munitions program began to absorb the unemployed. The service reverted to its task of caring for those on the Poor Roll. It later provided the core of a geriatric service.

⁹ Macgregor, *op. cit.*

¹⁰ *A Scheme of Medical Services for Scotland* (MacAlister Report), 1920, Cmd. 1039.

¹¹ *Annual Report of the Department of Health*, 1931, Cmd. 4338, p. 13.

the matter in detail.’¹² This was agreed and the committee began work in 1931. To the Department it had also been ‘apparent for some time that there are fields of medical investigation in which the private practitioner could make a valuable contribution, and that something has been lost to medical research in the past by the failure to fully appreciate the practitioner’s point of view and to utilise his experience.’¹³ A standing committee of the Department and representatives of the Scottish Committee of the BMA was set up in 1931 to investigate and keep under review the true extent of morbidity in Scotland. At that time the only statistics available were those extracted from the operation of the NHI scheme; it was now planned to improve the usefulness of these statistics by including the wider experience of general practice. By 1933, when Cathcart was exploring the possibilities for reform, the Department was confident that both its committees on general practice were proceeding successfully and their objectives already in sight.

In 1931 the Department had reported that the vital and morbidity statistics were ‘not so favourable’¹⁴ as they had been in previous years. Later, as the social distress caused by the Depression continued, health problems increased even further. The number of separate illness treated by general practitioner under the NHI scheme increased from 113,037 in 1930 to 400,052 in 1933, a rate of 227 for every 1000 patients insured.¹⁵ The pattern of morbidity also began to show some new and disturbing trends. The continuing marked fall in the severity of and the number of deaths from infectious disease was no longer causing a fall in the death rate; the overall death rate was increasing.¹⁶ The marriage rate and the birth rate had fallen to record lows but the number of attempted

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid., p. 14.

¹⁵ *Annual Report of the Department of Health for Scotland*, 1930, Cmd.3860, p. 193, and 1933, Cmd. 4599, p. 142.

¹⁶ Report from the Medical Officer of Health for Glasgow. *BMJ*, ii, 1933, p. 704.

abortions was increasing with a sharp rise in the number of maternal deaths from septic abortion.¹⁷ A study in Port Glasgow, one of the communities most affected by unemployment, found that the health of the children was clearly deteriorating.¹⁸ From Glasgow, the town with the highest proportion of its population on poor relief (17%) in the United Kingdom,¹⁹ it was reported that an exceptionally large number of patients were being admitted to mental hospitals, 'most of whom were acutely ill.'²⁰ As the health crisis continued across Scotland it seemed possible that, following the precedent in Glasgow, a general practitioner service might emerge on an *ad hoc* basis as, one by one, local authorities found themselves forced to set up schemes of their own. A second state general practitioner service would then have come into being, operating alongside, but independent of, the NHI scheme. Cathcart decided that a drift in that direction must be prevented since it would perpetuate the principal defect already found in the existing local authority medical services; operating under the constraints of local rates, developments would be haphazard creating a service that would be uneven across Scotland as some areas went ahead faster than others. It was also foreseen as inevitable that there would be wasteful overlapping and friction between two state-supported general practice services acting under separate administrations. Cathcart found that:

The case presented to us for organised provision for the dependants of the insured is irresistible, both on grounds of national health policy and on the narrower grounds of immediate administrative expediency in order to maintain the efficiency of the existing medical services, and to obtain full value from them...We therefore regard it as imperative for the State to frame a policy to meet the medical need of the dependants of insured

¹⁷ *Glasgow Medical Journal*, cxxvii, 1937, p. 292.

¹⁸ *Ibid.*, cxxiii, 1935, p. 8.

¹⁹ Liverpool came second at 11%. The rate for Scotland as a whole was 10.4% while in England it was 4.32%. *Reports to the General Assembly of the Church of Scotland*, xiv, 1935, p. 463.

²⁰ *BMJ*, ii, 1934, p. 131.

persons and others and to lay down the lines along which the medical service should develop.²¹

Cathcart proposed that the general practitioner services should be extended on the basis of the Nation Health Insurance scheme which already served 1,900,000 people in Scotland and employed the vast majority of Scotland's 5,162 doctors.²² Cathcart recommended that statutory provision for general medical attendance should be extended not only to the dependants of insured persons but to include all others in similar economic circumstances. Cathcart stressed that, as far as possible, the same general practitioner should care for the whole family and should act as its health advisor and liaise with the statutory health services. This concept had been well received when first put forward in the MacAlister Report in 1920. The Cathcart Committee therefore expected that it would again find support in 1936 especially since 'we were not prepared for the remarkable concentration on it, by local authorities as well as medical and other bodies, as the outstanding present need in any reform of the statutory medical services.'²³ A call for an openly available and comprehensive general practitioner service was included in the evidence submitted to the Committee by the Scottish Association of Insurance Committees, the Insurance Committees of Edinburgh, Glasgow and Aberdeen, the National Conference of Friendly and Approved Societies, the Convention of Royal Burghs, the County Councils Association and the Town Councils of Glasgow and Aberdeen.

The new role for general practice was also proposed by all the bodies representing the medical profession. The Royal College of Physicians of Edinburgh stated that 'the

²¹ Cathcart Report, p. 163.

²² This figure, which includes 832 women, is drawn from the local lists published in the *Medical Directory* of 1935. Many doctors holding hospital appointments as specialists also acted as general practitioners; many who were essentially general practitioners held appointments at voluntary hospitals. It is therefore not possible to distinguish clearly between consultants and general practitioners.

²³ Cathcart Report, p. 156.

family doctors must, in the opinion of the College, remain the pivot of all schemes which concern the national health; his responsibilities should be expanded.²⁴ This view was repeated in the submissions of the Royal College of Surgeons of Edinburgh, the Royal Faculty of Physicians and Surgeons of Glasgow, the Scottish Committee of the BMA, the Medical Practitioners Union, the Lanarkshire Medical Practitioners Union,²⁵ and the Society of Medical Officers of Health in Scotland. The Society of Medical Officers of Health stressed particularly the importance of the general practitioner in health education. 'To be efficacious health education should be as personal as possible. The family doctor would appear to the most suitable person to undertake this work.'²⁶

In Scotland, there was consensus among the representatives of all branches of the medical profession - general practitioners, hospital consultants and local authority doctors, not only on the place of the general practitioner but more generally on the need to 'make common cause' in the creation of a modern medical service.²⁷

Employment by the State

Cathcart's scheme for an extended general practitioner service would only be possible if the practitioners agreed to accept employment by the state. Differing views on the preferred basis of employment were discussed in the Report. Some younger medical graduates were known to favour a whole-time salaried service; in theory medical officers

²⁴ Ibid., p. 152.

²⁵ The largest of Scotland's many local general practitioner societies.

²⁶ Cathcart Report, p. 155.

²⁷ Ibid, p. 154. Historians have painted a different picture in England. e.g. 'Between the wars, when the foundations of the NHS were laid, the doctors were not united but split between three rival interests, each of whom hoped to dominate the emerging service: the voluntary hospitals, the insurance based panel doctor system and the local authority health services.' H. Perkin, *The Rise of Professional Society* 2nd ed. (London, 1990), p. 445

would be carefully selected and appointed within a career structure appropriate to civil servants. Whole-time contracts would ensure pensionable employment with provision for periods of annual leave and leave for further medical training. There would also be opportunities for promotion. The advocates of such a service believed that it would reduce to a minimum any temptation to put personal interest before the interest of the patient or the service.

Cathcart accepted the contrary argument that a whole-time service would militate against the full application of modern concepts of the practice of medicine. If a salaried service within the civil service was to offer an attractive career, medical officers would be in constant movement and promotions and transfers would involve frequent changes of personnel from one district to another. Medical officers, it was argued, would never remain long enough in one area to acquire the intimate knowledge of the patients and their home circumstances that would allow them to provide a service comparable to that provided by private practitioners. The suggested disadvantages of inadequate supervision and discipline were discounted on the evidence of the Highlands and Islands Medical Services which had 'demonstrated the practicability of ensuring satisfactory supervision in a service based on contract with private practitioners.'²⁸ It was further argued that in time, in a salaried service, contracts would be gradually adjusted and improved, reducing spells of duty, increasing periods of leave and creating more promoted posts. It was predicted that in the long run a salaried service would prove to be the more expensive option.

Cathcart concluded that the basis of employment should be, as in the National Health Insurance scheme, by contract for part-time services remunerated by capitation fees. The principle of free choice of doctor was to be preserved. This was considered to be essential in modern practice. 'Confidence between doctor and patient has become

²⁸ Cathcart Report, p. 168.

more important with the increasing frequency of psychoneurotic conditions and other ailments, the growing appreciation of early diagnosis and treatment and the function of the doctor as advisor on hygienic living as well as the treatment of disease.²⁹ It was also recommended that the training of the general practitioner should be widened 'to encourage the preventive outlook and equip him fully for the role of health advisor.'³⁰ 'The need for change in medical training is widely recognised in the medical profession.'³¹

Standards in General Practice

Cathcart's review of the general practitioner service was confined to its availability and scope; there was little reference to quality. No official or other assessment had been made by that time and the Committee attempted none. In general, the public seemed to accept whatever service could be found. But during the 1930s there were many protests in the correspondence columns of the *BMJ* and the *Lancet* from young doctors protesting about the impossibility of putting into practice what they had been taught in medical school.³² Many of the more senior general practitioners echoed the despair of a correspondent to the *Lancet* in 1933: 'the more highly equipped a man is for the task and the more conscientious and thorough he is in his work the more steadily and surely will the conclusion be borne in on him that the labour he has been set to do is intolerable and beyond the wit of man to accomplish.'³³

²⁹ Ibid., p. 167.

³⁰ Ibid., p. 169.

³¹ Ibid., p. 167.

³² A. J. Cronin, a Glasgow medical graduate, vividly described the limitations and frustrations of working class practice in Wales in his novel *The Citadel* in 1937.

³³ *Lancet*, ii, 1933, p. 265

Much of the hankering for reform among the medical profession in Scotland came from this dissatisfaction with the standards then being achieved in general practice. Senior members of the profession had witnessed little evidence of progress in line with the advances in medical science. Recent graduates from the Scottish medical schools were frequently disappointed and disillusioned by experience as assistants in practice, particularly if that first experience was south of the border.³⁴ The only study to describe conditions in general practice in the United Kingdom in the 1930s was not published until 1950. The author, J.S. Collings, found that the little change that had occurred over the years between the wars had been for the worse.³⁵ He concluded that, during those years, general practice as an institution had been in retreat from the dominance of modern medical practice in the hospitals and the introduction and expansion of the statutory medical services since the beginning of the century.

On the situation in England, Collings concluded that the overall state of general practice was bad and deteriorating.³⁶ In industrial areas where the demand for good medical care was greatest and most urgent, general practice had 'reached a point where it is at best a very unsatisfactory medical service and at worst a positive source of public danger.'³⁷ While shortcomings were often attributed to the volume of work, this was judged to be a convenient rationalisation of an otherwise embarrassing situation. The working environment of the industrial practice provided no comfort or convenience for the patient and the doctor was so limited by lack of space, equipment, and organisation that good practice was impossible. 'In the circumstances prevailing, the most essential

³⁴ This comment summarises the views expressed in recorded interviews of doctors in practice at that time. Those interviewed on this subject are listed in the Bibliography.

³⁵ The study was carried out by J. S. Collings, a research fellow in the Harvard School of Public Health who had graduated in medicine in Australia and had experience in general practice in New Zealand and Canada. His report was published in the *Lancet* in 1950. (*Lancet*, i, 1950, p. 555). Its findings were endorsed in a leading article that stated 'The issue has been placed squarely before us'.

³⁶ Collings, op. cit., p. 558.

³⁷ Ibid.

qualification for the industrial general practitioner, from the standpoint of public safety, is ability as a snap diagnostician, an ability to reach an accurate diagnosis on a minimum of evidence, objective or subjective.³⁸ Treatment was more limited even than diagnosis. 'It is rare indeed to see a practitioner in an industrial areas open an abscess, put in a suture or indeed undertake any procedure requiring sterilisation of instruments.'³⁹ Medical treatment was usually the 'bottle-of-medicine' from a stock mixture. No records were kept. Relieved of responsibility for school and pre-school children, for ante-natal care and midwifery, and more inclined to attend rather than care for the aged, the general practitioner was no longer a family doctor. Collings found that, broadly speaking, the doctors were of two types, the 'mercenaries' and the 'missionaries.' Among the missionaries were men of outstanding character and ability who had gone into practice to 'do good.' Among the mercenaries were some who 'by our accepted standards, are judged undesirables.'⁴⁰ However, mercenaries, with good skills of snap diagnosis were, in the circumstances, more effective than the missionaries. Under the conditions of industrial practice even the 'good' doctor had little opportunity to exercise the humanistic, psychological and educational functions which were essential to good family practice.

The important point is that this form of practice constitutes the pattern for most industrial areas, and the pattern is accepted by doctor and patient alike. It is far from the ideal of family doctoring on the one hand, and of modern scientific medical practice on the other; yet it is still wilfully identified with both these.⁴¹

The pattern of general practice in rural areas of England was found to be somewhat better. At a distance from large hospitals and fully developed local authority

³⁸ Ibid.

³⁹ Ibid., p. 559.

⁴⁰ Ibid., p. 558.

⁴¹ Ibid., p. 559.

services, the pattern of practice was determined largely by the personal choice and initiative of the doctor himself. Rural practitioners often undertook a high level of diagnostic responsibility. Some, especially those with access to reasonable cottage hospital facilities, could work to much the same level as a consultant physician. Others could at least equip themselves to a useful standard. But the majority adopted the same empirical methods as doctors in industrial practice. Similarly doctors in rural areas could perform even major operations if they had access to a well-equipped cottage hospital, or minor operations in their own surgeries. Some rural practitioners continued to do some of the midwifery in their areas. However, in general, medical treatment tended to be on the same 'bottle-of-medicine' principle as in industrial practice. Indeed many rural practices were little different from a run-of-the-mill industrial practice. The greatest difference was that the rural general practitioner dealt with patients of all ages and not primarily with the working section of the community. The range of the work undertaken in different practices varied but the rural practitioner still approximated to the ideal of the family doctor. However few rural doctors aspired to meet the demands of modern medical science and practice. Collings found that, in the final analysis, rural practice in England was an anachronism that had retained few of the virtues of the past.

In Scotland, Collings found that quality of general practice was higher and he had special praise for the practices in the north and west which formed part of the Highlands and Islands Medical Service. 'This service enjoys a high reputation internationally as well as locally. It is held up as an example of a well organised medical service giving medical care of high quality.'⁴² However, not all rural practices in Scotland reached this standard. There were some where

the continued failure to establish and maintain standards of medical care, and the continued acceptance that general practice is good for its own sake, has deadened the critical faculty and sensitivity of the best general

⁴² Ibid., p. 580.

practitioners, and has resulted in the decline of standards of practice to a dangerously low level.⁴³

Collings found that the worst in industrial practice in Scotland was at least equal to the 'good' in England. Although the surgeries were as forbidding as in England, they were better equipped. Every practice had an examination couch; sterilisers were almost always available and instrument cupboards were well stocked. A conscious effort was nearly always made by the doctor to conduct some sort of useful physical examination. In absolute terms, these were by no means good examinations but they were purposeful and at least eliminated some dangerous possibilities. As a rule the minor laboratory tests, essential for reliable diagnosis, were done. Patients were not referred to outpatient departments with quite the same readiness and lack of inquiry or thought as in the industrial practices in England. There was also a consciousness of the need for records and records were always kept in some form. In the practices where lists were full (4000) and the doctors were busy, there was nothing like the congestion or lack of organisation found in comparable practices in England. Collings found the influence exercised by the doctors on the family to be notably stronger and sometimes of educational value.

While the difference in practice in the two countries was principally one of degree, there were important differences in form. In Scotland dispensing practice had never reached the same proportions as in England, and the 'bottle-of-medicine' mentality had not been developed by doctor or accepted by the patient. In Scotland the doctor had retained some responsibility for mothers and children and, in general, had remained much more the family doctor than in England.

⁴³ Ibid.

However the greatest difference between the doctors of the two counties was one of attitude.⁴⁴

The attitude of most general practitioners to both local and central authority, as represented by city and county health departments and the Department of Health for Scotland, seems more reasonable and co-operative than that of English doctors to the corresponding authorities there. Though it could be not be said that the relationships are by any means ideal, for the most part they were at least workable.

In England any association, real or imaginary, between my survey work and local or central authority militated against good relations and created obvious suspicion. In Scotland, on the other hand, wherever I went I found I could use either a local authority or the Department of Health as a means of introduction to general practice, without embarrassment and without arousing any serious misgivings. Indeed in one part of Scotland I actually travelled with an officer of the Department, who accompanied me into the various practices I visited; and the doctors were quite as frank in his presence as if I had been alone. In England, on the few occasions when I was introduced by such an officer, I found relations with the doctors strained until I had explained my association with, and established my independence of, officialdom.

The explanation that has been offered me for this difference – that it is merely a matter of size – is not good enough. The relationships in country towns in England are often worse than comparable relationships in big cities in Scotland. There is a basic difference in attitude of mind.

This difference in attitude is reflected in other ways. In England discussion with general practitioners on the new health service usually centred on the size of capitation fees, the number of patients on the list, mileage rates, basic salaries, and so on, until it was steered into professional channels. In Scotland I found much more spontaneous interest in professional issues such as the quality of medical service, the relationship of general practice to hospital and specialist services, and the development of health centres.

I do not wish to give the impression that I am attributing all good to the Scottish doctor and all bad to the English. That is not the case at all. But there is an appreciable difference.

⁴⁴ The differences described by Collings are in accord with the experiences recounted in the recorded interviews referred to above. Although differences were well recognised within the medical profession by those who had practised in both sides of the border they have seldom been recorded so accurately. Collings' comments are therefore quoted at length.

I was similarly impressed by the difference in attitude to general practice (in the two countries) among specialists who had thought deeply about general practice. In England there was little genuine respect for general practice or the average general practitioner. Much more respect was shown by the corresponding Scottish specialists, and their criticisms of general practice were almost always constructive and sympathetic. Similarly the attitudes of representatives of organised medicine towards the new service seemed to me more objective in Scotland than in England.⁴⁵

While general practitioners in Scotland in the 1930s had retained some of the traditional characteristics of the family doctor, even in Scotland the average general practitioner was not the doctor that Cathcart had in mind for the general practitioner of the future. To Cathcart, it seemed desirable that in a new service the working practices of general practitioners should be supervised.⁴⁶ And in preparation for their extended role as health educators, medical attendants and liaison with special services, appropriate changes in their training were clearly necessary.⁴⁷

The Prospects for Consent

Cathcart proposed that the proposed general practitioner service should be developed on the basis of an extended National Health Insurance scheme. Since the scope of the medical services and the terms of employment of doctors in that scheme were uniform across the United Kingdom, it was inconceivable that Cathcart's scheme could be introduced only in Scotland. The necessary legislation, which could only be agreed in London, must be found acceptable south of the border. While there were sound reasons to suppose that the medical profession in Scotland would be very ready to accept the

⁴⁵ Ibid., p. 579.

⁴⁶ Cathcart Report, p. 304.

⁴⁷ Ibid., p. 169.

proposed new role, there were equally good reasons to suppose that the concept would be less welcome in England.

In Scotland the idea of a new role had been taking root for some years. MacAlister's 'exposition of some general principles' that should govern general practice had been accepted by the Scottish Board of Health as a guide for future policy and these principles had been promoted in the Scottish medical schools between the wars (Chapter Two).

Traditionally the medical profession in Scotland was predisposed by its training and its established ethos toward public service. In the 1930s there was a more immediate factor that made employment by the state increasingly attractive. Opportunities for employment in Scotland were becoming fewer. In the years from 1927 to 1933 the number of doctors employed in England had increased by over 11%, while in Scotland over 500 jobs had been lost.⁴⁸ At the same time the number of doctors being trained in Scotland continued to increase. In Glasgow, clinical teachers found that the number of their medical students was continuing to rise beyond the number that could be assured of the necessary clinical experience. (In 1939 it was eventually found necessary to restrict the number of students in Glasgow to a total of 240 from the United Kingdom and 60 from overseas.⁴⁹) Throughout the 1930s the opportunities for Scottish graduates to find employment in their own country were diminishing. In the circumstances the prospect of employment in a state-maintained service was becoming increasingly attractive in Scotland.

In England the medical profession was neither disposed to become the servant of the state nor was it difficult for medical graduates in England to find employment where job opportunities were increasing. There was little incentive to make radical changes. In 1920, the Consultative Council on Medical and Allied Services of the Ministry of Health

⁴⁸ *Medical Directory* 1927-1933.

⁴⁹ *Minutes of the Royal Faculty of Physicians and Surgeon of Glasgow*, 23 July 1939.

had produced an interim report on *The Future Provision of Medical and Allied Services* (Dawson Report).⁵⁰ Dawson's scheme for England and Wales was similar to MacAlister's scheme for Scotland (though significantly more hostile to a salaried service). But as Pater records, 'the conclusions of the interim report carried little weight because they were opposed by a substantial body of opinion on the council, and the production of the report was rushed so that the dissidents were prevented from expressing their opposition.'⁵¹ The Minister of Health was hesitant in his acceptance of this interim report, issuing only a brief statement referring to the possibility of reform of the Poor Law. A final report was never produced. The Dawson Report was recalled during the final planning of the National Health Service in the 1940s but there is nothing in the Annual Reports of the Ministry of Health or the Annual Reports of the Chief Medical Officer to suggest that the Dawson Report, with its new role for the general practitioner, received active support in England during the 1930s. Nor is there evidence that the Ministry of Health made any attempt to emulate the Department of Health for Scotland in working to achieve the co-operation among the various sections of the health services in England which might lead to the creation of a new unified (or even co-operative) medical service sponsored by the state.

In the schemes proposed for Scotland, initially by MacAlister and now in the 1930s by Cathcart, it was essential that the general practitioner should become more absorbed into public service and employment by the state. There were good reasons to believe that this shift would be more readily acceptable to doctors educated in Scotland than by those who had been schooled in a different tradition in England (Chapter Two). Over the years teaching was modified in keeping with changes in medical science and practice. But in its principles it continued unchanged and instruction in each new branch

⁵⁰ *The Future Provision of Medical and Allied Services* (Dawson Report), 1920, Cmd.693.

⁵¹ J. Pater, *The Making of the National Health Service* (London, 1981), p. 10.

of medicine, as it established its place in the widest concept of medical practice, was included in the curriculum. A Scottish degree became recognised as an excellent qualification for a career in various forms of medical practice. Many Scottish graduates made their careers in public health,⁵² in the armed services, in the colonial medical services.⁵³ (In 1935, 15 of the 29 Medical Officers of Health in the administrative County of London were Scottish graduates; Scottish graduates made up 25% of the total medical personnel of the Naval, Military, Indian and RAF Services.⁵⁴ When the Indian Medical Service was at its highest strength 30 % of its medical officers were Scottish graduates.)⁵⁵ A few achieved success in entrepreneurial private practice in London and Harley Street. But the great majority, not only those who remained to practice in Scotland, continued in the Scottish tradition in which service to the state or to medical science could confer a status that could only be achieved in England in entrepreneurial private practice. The medical schools in Scotland had been first promoted by the state in the shape of the local authorities, and for the benefit of the state. They generated a discourse and rhetoric in which public service was highly regarded. It may be argued that the students entering the medical schools were already more predisposed to employment by the state than students south of the border. While the breadth of the curriculum and the quality of the instruction were the outstanding attractions, the Scottish medical schools also offered the added advantages of ease of entry, religious tolerance and economy of fees and living expenses.⁵⁶ Scottish students were drawn from a wider spectrum of society than those of the English, particularly the London, medical schools. On 1901 the *Edinburgh Medical Journal* reported:

⁵² *Medical Directory*, 1935.

⁵³ The remaining 75% were made up of medical officers from Ireland, England, India, New Zealand, Canada and Australia.

⁵⁴ *Medical Directory*, 1935.

⁵⁵ D G Crawford, *Role of the Indian Medical Service* (London, 1930).

⁵⁶ In 1901 annual fees at Glasgow were £126 and at Aberdeen £113. Fees at Oxford were £220 and at Cambridge £200. *Edinburgh Medical Journal*, x, 1901, p. ii.

Through the munificence of Mr. Andrew Carnegie cost of academic training had been lessened by the payment of the education fees in the case of students of Scottish Nationality and also those who have attended any scholastic institution under the inspection of the Scotch Education Department of whatever nationality during at least two years after the age of fourteen.⁵⁷

The interest on Carnegie's endowment of £2,000,000 was to provide bursaries to students 'in the hope that only those who require help will apply although no question as to the circumstances are asked from the claimant.'⁵⁸ The bursaries so openly available from the Carnegie Trust had an immediate effect on recruitment to Scottish universities. By 1910, at Glasgow, the percentage of working class students had risen to 24%, a proportion that continued thereafter throughout the 1930s.⁵⁹ The usual ambition of a child of working class parents was to become a teacher.⁶⁰ The longer training for medicine required, in addition to the support of the Carnegie Trust, considerable financial sacrifice by the parents. The proportion of working class students in the medical school was therefore less than the general level in the university.⁶¹ Nevertheless medical students at Glasgow and the other Scottish medical schools were not perceived, and did not perceived themselves, as an elite. They received their medical training in a culture that did not regard entrepreneurial success as the most laudable of ambitions.

In Scotland, general practitioners, who made up the great majority of the medical profession, operated in a society culturally and economically distinct from that in England. The profession in Scotland had its own place in society, its own system of

⁵⁷ Ibid.

⁵⁸ Ibid.

⁵⁹ K. Collins, *Go and Learn: The International Story of Jews and Medicine in Scotland* (Aberdeen, 1988) p. 28.

⁶⁰ Ibid. p. 29.

⁶¹ Ibid.

values and its own characteristics – notably a higher proportion of women⁶² and a much higher proportion of university graduates.⁶³ But in spite of the shared characteristics of its members, the profession in Scotland did not function as a corporate entity. The great majority of doctors practised independently, either alone, possibly with an assistant, or in a very small partnership. Their loyalties were to the local community rather than to any central organisation. For professional guidance and direction general practitioners looked to the local university centre at which, in most cases, they had been trained. There was no one national centre in Scotland on the model of Harley Street to which patients from all over England and Wales were referred for an ultimate authoritative opinion. That part of Scottish society that might have supported such a centre of fashionable practice had, for many years, taken ‘the social high road to London.’⁶⁴ Politically the medical profession in Scotland had no established or influential leadership. Only a small minority of Scottish general practitioners had any continuing association with the Royal College of Physicians of Edinburgh, The Royal College of Surgeon of Edinburgh or the Royal Faculty of Physicians and Surgeons of Glasgow. Although these corporations together made up one of Britain’s most important licensing bodies, they were principally concerned with the maintenance of standards in specialist and consultant practice. Although called from time to time to respond to questions of national importance they were not inclined to be politically pro-active. Politically the medical press in Scotland, the *Edinburgh Medical Journal* and the *Glasgow Medical Journal* echoed the activities of the Royal Colleges and the Royal Faculty which sponsored them, but gave first place to their roles as scientific journals.

⁶² The proportion of women in Scotland was 16.2% and in England 9.4%. Figures derived from the local lists of the Medical Directory for 1935.

⁶³ In England the proportion of non-graduates was 32.5% and in Scotland 6.4%. Ibid.

⁶⁴ N. T. Phillipson, ‘Nationalism and Ideology’ in J.N. Wolfe (ed.) *Government and Nationalism in Scotland*, (Edinburgh, 1969), p. 170.

General practitioners in Scotland related more to local associations rather than to any national body. Since the middle of the eighteenth century 135 local medical associations had been formed in Scotland;⁶⁵ in the mid 1930s some 37 were still in being. The objectives of these associations varied from those few with a very specific professional purpose (e.g. the Edinburgh Missionary Society was formed to train medical students for mission work overseas or at home) to those which were no more than closed dining clubs (e.g. the Harveian Society initially limited to 30 fellows of the Royal Colleges in Edinburgh meeting for an annual dinner and oration.) The great majority were founded 'to provide friendly and social intercourse between members of the medical profession'⁶⁶ and 'for the purpose of writing and discussing medical subjects.'⁶⁷ The medical subjects might include the presentation of difficult or interesting cases or the presentation of a scientific paper. These societies also met, as occasion arose, to agree such local matters as staffing arrangements for the local voluntary hospital, local schedules of fees, or salary levels to be paid to assistants. In the 1930s they also met to co-ordinate resistance to the increasing encroachments on their practices by the rising auxiliary professions of pharmacy and midwifery.

The interests of these societies remained essentially local. There was little inclination among them to come together to form a national body. An Association of Scottish Medical Practitioners was formed in 1859 to help in the enforcement of the Medical Act of 1858 but within a year it was in 'a state of suspended animation.'⁶⁸ In 1865 a number of medical societies in the north came together as the North of Scotland Medical Association; the Association gradually faded away to become extinct after some twenty five years leaving its constituent local societies still in existence. The arrival of the

⁶⁵ The societies are listed by J. Jenkinson, *Scottish Medical Societies, 1731- 1939*, (Edinburgh, 1993)

⁶⁶ Quoted from the objects of the Western Medical Club. Ibid., p. 203

⁶⁷ Quoted from the objects of the Glasgow Medico Chirurgical Society. Ibid., p. 161.

⁶⁸ *Edinburgh Medical Journal*, vi, 1860, p. 775.

British Medical Association in Scotland in 1872⁶⁹ was not greeted with enthusiasm. Many societies regarded it as a threat to their independent existence; some, on the other hand, mooted the formation of a Scottish Medical Association to recognise and maintain the distinct nature of the profession in Scotland.⁷⁰ The BMA gained ground only slowly even after Scottish Committee of the BMA was set up in 1903. As the number of BMA branches increased in Scotland the local associations continued to retain some interest in political matters, often in opposition to the policies of the BMA.⁷¹ Within a few years the Scottish Committee was itself dissatisfied with its relationship with the central body of the BMA in London; the Scottish Committee felt that the Association was not taking as active a role in watching Scotland's interests as it might.⁷² The Scottish Committee therefore tended to pursue its own line when necessary in the interest of medical services in Scotland. In sharp contrast with the confrontation between the BMA and the Ministry of Health in London, the Scottish Committee established and continued in a constructive relationship with the Scottish Board of Health from 1919 and with its successor the Department of Health for Scotland from 1929.

Membership of the BMA was not high in Scotland. In 1935 only 50.9 % of doctors in Scotland were members.⁷³ For most doctors the chief attraction of membership was the *British Medical Journal* which, apart from publishing scientific papers, acted as the profession's employment agency⁷⁴ and gave notice of matters of essential importance to medical practice. It also reported on the activities of the central body of the BMA. For most general practitioners, even for members of the BMA, the journal was the only

⁶⁹ Founded originally as the Provincial Medical and Surgical Association, the BMA had been functioning in England since 1832.

⁷⁰ Jenkinson, op. cit., p. 81.

⁷¹ Ibid., p. 82.

⁷² e.g. Memo from the Scottish Committee to the Council of the British Medical Association. LHB 1/60/15.

⁷³ *Annual Handbook of the BMA*.

⁷⁴ It was known to the children of one former colleague as 'daddy's job book.'

contact with the political apparatus of the BMA. Few members were active within the Association or attended meetings. A review of the minute books of the branches and division of the BMA in Scotland in 1935 shows that attendance at meetings averaged some 4% of the membership (2% of the medical profession) in Scotland. The largest numbers attended meetings in the cities; in Ross and Cromarty where the membership was 43 no meetings could be convened in that year. Poor attendance at meeting did not necessarily indicate a lack of interest; general practitioners, especially those in single-handed practices, found it difficult to travel to meetings leaving their practices unattended. There was therefore a severe, even crippling, lack of communication within the BMA. Although the membership could hear of the activities of the leaders as reported in the *British Medical Journal*, the leadership could only gather the opinions and hear of the problems of the very few members with the leisure to attend meetings.⁷⁵

The views of the individual general practitioners were of crucial importance. The health policy advocated by the Cathcart Committee could only go forward with their support. Without their active participation the whole scheme would be impossible. The representatives of all the medical bodies in Scotland had indicated to the Cathcart Committee that the policy would find willing co-operation. However there was no organisation through which the views of general practitioners, dispersed independently across Scotland, could be accurately assessed although there was good reason to expect that Cathcart's proposals would be welcomed. In the Highlands and Islands Medical Service general practitioners in Scotland had already shown that, given the opportunity to join a state scheme, they were more than ready to take it. From at least 1931 the Department of Health had gone forward on that assumption.

However the re-structured general practitioner service advocated by Cathcart could not be put in place in Scotland alone. Planned as an extension of the NHI scheme it

⁷⁵ There was no arrangement for postal voting.

could not go forward except as a national plan agreed at Westminster. In England there could be no certainty that the medical profession would be willing to give the necessary backing to such a scheme and there was good reason to suspect that it would not. The precedent of the resistance to the NHI seemed ominous. However in England in 1911, as in Scotland, the rank and file of the profession had not had a clear opportunity to make their views known or to confirm their individual support for those who had taken it upon themselves to speak on their behalf. There was no reason to suppose that, in creating an extension of the NHI scheme, those speaking for the profession in London would be more accurate in voicing the views of the rank and file. In the United Kingdom the attitude of general practitioners to a new and extended role in a scheme which involved employment by the state could only become known with certainty when its individual members were given the opportunity to join. But there was reason to suppose that the new form of general practice would be welcomed in Scotland.

CHAPTER NINE

THE CATHCART REPORT: REACTION AND REPOSE

The Reaction

The Report of the Committee on Scottish Health Services was published as a Blue Book on 2 July 1936. There was little reaction from the general public. For months the dominant interest of mass circulation newspapers had been the failure of the League of Nations to prevent Mussolini's invasion of Abyssinnia and the implication for world peace. On that day in July the front pages were given over to reports on the meeting of the Assembly of the League of Nations in Geneva at which Anthony Eden, the Foreign Secretary, was attempting to restructure an organisation in danger of falling apart. Leader writers were already commenting anxiously on the 'mad folly of the arms race in Europe.'¹

Even in this climate of gathering crisis the Cathcart Report did not pass entirely unnoticed. Summaries of its findings and recommendations were set out in the inner pages of the broadsheets. The *Glasgow Herald* commented on the importance of the Report and predicted that it would be debated 'for a long time to come.'² The *Scotsman* devoted two full columns to 'this voluminous report,'³ describing it in an editorial as a careful and exhaustive study that must command respect. The *Scotsman* accepted the Report's analysis of Scotland's health problems without question and approved the policy

¹ *Scotsman*, 2 July 1936.

² *Glasgow Herald*, 2 July 1936.

³ *Scotsman*. op. cit.

it put forward.⁴ But prompt action to implement that policy was judged to be unrealistic since it would necessarily involve 'legislation on a big scale.'⁵ *The Scotsman* preferred to give its immediate support to the efforts then being made by the government to honour the pledge made in its election manifesto to relieve the country's most immediate and pressing health problems. The Midwifery Bill and the Scottish Education Bill, both before Parliament in 1936, were seen as practical measures that must have priority over any consideration of idealistic plans for the long term.⁶

The Scotsman's position was eminently reasonable and widely shared. The problems addressed by these two Bills had become urgent. The maternal mortality rate in 1935 was higher than it had been ten years before.⁷ The incidence of puerperal sepsis had increased even since the previous year. Taken together the total of maternal deaths, still births and neonatal deaths was now greater than the number of deaths from cancer and greater even than the total number of death from infectious disease.⁸ The *Report on Maternity Morbidity and Mortality in Scotland*, published in 1935, had not only exposed the full extent of this loss of life, it had identified critical deficiencies in the existing maternity services. The measures proposed in the Maternity Services (Scotland) Bill were intended to bring under control a loss of mothers of families that was becoming a national

⁴ Sir John Brotherston's interpretation (G. MacLachlan, *Improving The Common Weal* (Edinburgh, 1987), p. 77.) is unsatisfactory. Sir Andrew Grierson's reasonable anxiety about the cost of Cathcart's proposals, which Brotherston records as an objection to the Report, was expressed in the Report itself and signed by Sir Andrew. *The Scotsman* did state that the 'whole system is really not far removed from a State medical service' but not as a condemnation as Brotherston implies. Brotherston's further comment that the newspaper editorials 'appear to be in line with the prevailing views of Scottish conservative politicians' is offered without supporting evidence. In my own reading of the editorial, the *Scotsman* accepted Cathcart as 'jam' although, regrettably, 'jam tomorrow.'

⁵ *Scotsman*, op.cit.

⁶ Ibid.

⁷ For the five years 1931-1935 the average maternal mortality rate was 6.1 per 1000 births, sepsis accounting for 2.5 and other causes 3.6. *Annual Report of the Department of Health for Scotland*, 1937, Cmd. 5713, p. 67.

⁸ *Transactions of the Edinburgh Obstetrical Society*, xcv, 1935-36, p. 21.

scandal. Reports on the health of Scottish children were also alarming; in the single year to 1936 the infant mortality rate had risen from 76.8 to 82.⁹ Over that same year the death rate of children between the ages of 1 and 4 years had increased from 6.8 to 7.6.¹⁰ School children continued to reveal 'a considerable mass of health defect';¹¹ it was hoped that the welfare provisions in the Education Bill might effect some improvement.

The priorities of *The Scotsman* and the public were shared by Scotland's general practitioners. They too were more focussed on the immediate plans for improving maternity services than on plans for a possible revolution in general practice at some time in the future. The publication of the Cathcart Report prompted no special meetings of the BMA. The regular meetings of local Divisions attracted no more than the usual small number of members.¹² In normal times few ordinary members of the BMA could easily find the time or the motivation to overcome the difficulties in arranging locum cover for their practices and making the journey to attend meetings, often at some distance from home. Only when there was some real or perceived threat to their practice conditions (as during the negotiations before the National Health Insurance Act of 1911) or when concerted action was required in support of some national emergency or campaign (as for civil defence or for the control of tuberculosis) did practitioners rally in large numbers to the BMA.¹³ The absence of such coming together in 1936 may be taken as a sure signal

⁹ *Annual Report of the Department of Health*, 1936, Cmd. 5407, p. 60.

¹⁰ *Ibid.*

¹¹ *Ibid.*, p. 73.

¹² Meetings of the Branches of the BMA were essentially social events attended only by those few who could easily afford both the time and the cost of the occasion. Meetings were convened at an agreeable hotel for lunch, with opportunities for golf or fishing or for a visit to some local place of interest for those less inclined to sport. The number attending might be 20 to 40 including wives. BMA political business was normally discussed at meetings of Divisions at which there was often great difficulty in securing a quorum. The records (Archive, BMA House, London) of the Divisions of the BMA in Scotland in 1935 show that on average meetings were attended by 4% of the membership, i.e. 2% of doctors registered in Scotland.

¹³ The position of the BMA was problematic. It had no Charter to speak for the medical profession and in 1936 the BMA was not a trade union; it was a limited liability company

that Scotland's general practitioners found nothing in the Cathcart Report that required immediate action or seemed other than potentially welcome for the future. It may be assumed that they were content to wait in silence to examine the legislation expected in due course. Meantime more immediate concerns commanded their attention. In the months following the publication of the Report, routine meetings of Divisions were taken up by discussion of the organisation of the new services proposed in the Maternity Services (Scotland) Bill.¹⁴ A meeting of the Lothian Division was typical of Divisions across Scotland.¹⁵ Attended by only 19 members, the meeting decided that, as the proposed new maternity service was 'likely to be of benefit to the community,'¹⁶ general practitioners should give it their full support.¹⁷

But within a few months the focus of attention was shifting much more urgently to preparations for war. Again in Lothian, a meeting in October 1937 attracted 392 members for instruction on Air Raid Precautions and similar meetings across Scotland commanded even greater attendances, some of over 500. The Cathcart Report did not find a place on the agendas of BMA meetings in Scotland. The passing into law of both the Maternity Services (Scotland) Act and the National Insurance (Juvenile Contributors and Young Persons) Act in 1937 (below) called for new practice arrangements and for new relationships to be developed with local authority services. At the same time the staffing of general practices had to be re-arranged in preparation for the expected loss of large

licensed by the Board of Trade. F. E. Freemantle, *The Health of the Nation* (London, 1927), p. 152.)

¹⁴ The Minutes of the Branches and Divisions of the BMA are retained in the Archive of the BMA, BMA House, London. The collection of the Minutes for the 1930s is complete except for those of the Dundee and Fife Branches.

¹⁵ Minutes of the Divisions of the BMA in Scotland.

¹⁶ Minutes of the Lothian Division of the BMA, 1935-37.

¹⁷ The meeting also decided that 'the suggested fee of £1 10s is inadequate.' At the following meeting the Division accepted that an amended fee of £1 17s was adequate. Minutes of the Lothian Division of the BMA, 17 November 1937.

numbers of doctors to military service. For the moment, a plan for a health policy for a very uncertain future was an irrelevance.

Scotland's many medical societies, which invariably attracted many more members than meetings of the BMA, did not, as a rule, concern themselves with political matters nor were they concerned with administration or organisation of services. During the gathering crisis they continued to hold their normal clinical and social meetings without reference to politics, either national or medical. The Medico-Chirurgical Society of Edinburgh and the Edinburgh Clinical Club were exceptional in holding a special joint meeting to discuss the Cathcart Report. That meeting provides a unique insight into the immediate reaction of general practitioners in Scotland to the recommendations of the Cathcart Report. The meeting, attended by 64 practitioners, unanimously resolved

to record its sense of the great value of the service rendered by the Committee on Scottish Health Services in their detailed and comprehensive study and analysis of the health problems in Scotland and the preparation of this most valuable report. The meeting is in agreement with the principles of the recommendations in the Report for improvement in the health services and venture to hope that legislative action may be taken at the earliest possible moment to give effect to the proposals of the Committee.¹⁸

While the great majority of the rank and file of the medical profession chose not to make public their views of the Cathcart Report, in 1936 their professional bodies saw no need to do so. The Cathcart Report was, in effect, their report. The Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, the Royal Faculty of Physicians and Surgeons of Glasgow, the Society of Medical Officers in Scotland and the Scottish Committee of the BMA had all given carefully considered and extensive evidence to the Cathcart Committee and their submissions had been incorporated in its Report. No further statement of their views on the future of medical services seemed

¹⁸ *Transactions of the Medico-Chirurgical Society of Edinburgh*, cxvi, 1936-37, p. 1.

necessary when the Report was published. Scotland's medical journals reflected the position of their sponsors. The *Glasgow Medical Journal*, sponsored principally by the Royal Faculty of Physicians and Surgeons of Glasgow, made no mention of the Cathcart Report in its Current Topics column. The *Edinburgh Medical Journal*, sponsored by the Edinburgh Colleges, did not depart from its normal practice of publishing only clinical and scientific material.

The expectant silence of the medical profession in Scotland is easy to understand. The principles on which the Cathcart Report was based had become familiar over the years since 1920. The Consultative Council on Medical and Allied Subjects, appointed within months of the creation of the Scottish Health Board in 1919, had set out these same basic principles in its first report, *A Scheme of Medical Service for Scotland* (MacAlister Report).¹⁹ MacAlister had drawn attention to the shift then taking place in public health from a system that dealt mainly with human aggregates and their hygienic environment to a system that included medical care for the individual patient and the safeguarding of the health of the individual citizen. MacAlister welcomed that shift. For MacAlister it was also 'of primary importance that the organisation of the Health Services of the nation should be based on the family doctor as the normal medical attendant and guardian.'²⁰ His report recommended the formation of health centres and that the benefits of the National Health Insurance Scheme should be enjoyed by the dependent families of the insured and extended to include specialist consultant services and domiciliary nursing. It also proposed reform of the Poor Law Medical Service and the development of local authority provision to include general medical services. MacAlister had welcomed the special medical services that had recently been introduced for mothers and infants, for school children and for workers, but criticised the lack of any single well-organised plan. MacAlister's ideas were carried forward by later committees

¹⁹ *A Scheme of Medical Service for Scotland*, 1920, op.cit.

²⁰ *Ibid.*, p. 6.

appointed first by the Scottish Health Board (Mackenzie Committee) in 1926²¹ and later by the Department of Health for Scotland (Walker Committee) in 1933.²² In 1936 the Cathcart Report again stressed the need for the single well-organised plan that MacAlister had found lacking in 1920.

The policy set out in the Cathcart Report was a further development of ideas promoted in Scotland since the creation of the Scottish Board of Health at the end of the First World War, but now placing a new and greater emphasis on the responsibility of the individual to promote and maintain his own health. From its beginning the Scottish Health Board and its successor, the Department of Health for Scotland, had made it their policy to maintain open and frequent communication with all the bodies with a responsibility for health care in Scotland. In appointing advisory committees they had always been careful to include members who could speak for all the bodies with a relevant interest and a consensus had been consciously and carefully nurtured. The principles underlying the Cathcart Report had grown out of previous reports and the Cathcart Report itself was an expression of the consensus that had grown over the years.

The Report was approved and signed by every member of the Committee. Inevitably some differences of view had emerged during the preparation of the Report and these were made public in appendices to the Report. The most important of these centred on how far and when the general practitioner service was to be extended. There were those²³ who feared that the service, as proposed, would be extended too far and too quickly, making demands of the general practitioners for which they were not yet prepared. The Report called for maternity services to be provided by the family doctor although it was known that, in 1936, few general practitioners had been trained for that role. There was no certainty that all family doctors would be willing to take on the role of

²¹ *Report of the Hospital Services (Scotland) Committee*, 1926, op.cit.

²² *Report on Hospital Service* (Walker Report), 1933.

²³ Dr. Alexander Macgregor, Lady Mackenzie, Violet Robertson and Joseph Westwood.

obstetrician at once or be able to perform in that role to an acceptable standard if it became necessary. To meet the immediate crisis in maternity care three members would have preferred an *ad hoc* service administered by the local authorities and staffed by midwives and obstetric specialists.

On the other hand, some members of the Committee thought the general practitioner service should be extended further than the Report envisaged. A general practitioner service based on the principles of the NHI Scheme might prove to be of insufficient help to the aged, the infirm, chronic invalids and 'various non-social or anti-social types.'²⁴ One member feared that the services of general practitioners would prove too expensive since, in their evidence, the representatives of the medical profession had made it clear that they would expect 'to get such advantages of the public services as superannuation, limitation of hours, holidays with pay, etc.'²⁵ while another thought that the 'sum suggested by the Committee dealing with the General Practitioner service' would not 'provide adequate remuneration.'²⁶ One member, while approving of the proposed general practitioner service, was not certain that it would be altogether effective in 'large centres of population where problems of a special kind and magnitude are met with.'²⁷

There were also different views on the most suitable administrative arrangements for local authority services. One member, himself an officer in local government, believed that for the efficient administration of public health services, to give local authorities discretionary powers to co-operate and to combine would achieve very little. 'This method has failed to a very large extent in the past.'²⁸ He proposed that the

²⁴ Cathcart Report, p. 356.

²⁵ Ibid., p. 345.

²⁶ Ibid., p. 362.

²⁷ Ibid., p. 356.

²⁸ Ibid., p. 365.

Department of Health should be the single administrative authority with increased powers of direction.

The recommendation on which the greatest number of Committee members had strong reservations was the proposal to transfer the functions of the Insurance Committees to the local authorities. The Chairman and four other members believed that this was undesirable; 'the relationship to-day between the committees, societies, doctors, dentists and chemists in Scotland is of the most friendly nature with a resulting smoothness of working which holds out little hope of improvement.'²⁹ It was well known that local authorities were not highly regarded by any group of health professionals and that their imposition as employers would be very vigorously resisted by doctors.

Only one member, Sir Andrew Grierson, the Treasurer of Edinburgh, was uncertain about the wisdom of pressing ahead so soon. He believed that the programme set out in the Report might be too precipitate, too risky and potentially too expensive. While conceding that the existing arrangements for the administration of the country's health services were 'in an inchoate state,' the Local Government (Scotland) Act of 1929 had put the administration of the health services 'on a higher plane than it had ever been before.'³⁰ In his view the provisions of that Act should have a proper trial and further development and improvements should only go ahead in the light of experience yet to be gained. The most pressing reason given for change had been that the existing arrangements failed to make provision for the large number of people who were not getting proper medical attention - in particular those who were outwith the scope of the National Health Insurance Scheme and could not afford private medical care. Sir Andrew predicted that the number of people in that position would diminish in time. Even while the Committee had been at work there had been 'a remarkable improvement in the economic circumstances of the people and there is equally a remarkable improvement in

²⁹ Ibid., p. 365.

³⁰ Ibid., p. 341.

the health of the people. Both as regards standard of living and as regards health, the condition of the people was never better than it is now.³¹ Sir Andrew believed that all that was needed immediately was more efficient organisation and administration of and by local authority services. Meanwhile the status of the general practitioner should remain unchanged. He was reluctant to rush into an extended contributory scheme for general practice that seemed likely to break down leaving an additional burden on the rates.³² Sir Andrew's case for delay found no support from other members of the Committee.

Among the members of the Cathcart Committee there were differences of emphasis, differences in priorities and differences about timing, but the majority view prevailed. The consensus that had been fostered over the years by the Scottish Health Board and the Department of Health remained intact. The members of the Committee could speak for the various interests in the provision of health services in Scotland and they were all agreed that the plan set out in the Report offered the best way forward.

This plan had been evolved by Scottish institutions over many years against the background of health problems and social conditions that were peculiar to Scotland. But Professor Cathcart had, for many years, been an influential advisor to government in Whitehall and other members of the Committee had public interests outside Scotland. It may therefore be assumed that the Cathcart Committee had it in mind that its Report should give a lead for the reform of health services in the United Kingdom generally. However it was by no means certain that a plan that found general acceptance in Scotland would be equally acceptable in England and Wales. There the relevant institutions had a different history and structure and the health and social problems were different in scale and distribution if not in kind.

³¹ Ibid., p. 342.

³² Ibid., p. 349.

How widely the ideas put forward in the Cathcart Report were, in fact, welcomed as appropriate south of the border cannot be known but the reaction of the medical press in London was favourable. The *Lancet* found some of the Report's administrative proposals, particularly the proposal to retain the contributory principle in financing the general practitioner service, to be 'highly controversial.' Nevertheless, the *Lancet* recognised the Cathcart Report as the most comprehensive inquiry yet carried out into the provision of community health care and urged that it should be carefully studied by all 'those in any country who have public health progress at heart; for health problems transcend national frontiers and have in them much that is common in all countries.'³³ The *BMJ* was even more positive: 'This publication should mark the setting up – perhaps at no distant date – of a comprehensive national health or medical service.'³⁴ To the *BMJ* it was 'extremely satisfactory' that the Cathcart Report was founded on the same principles and advocated the general policy already put forward by the BMA in its pamphlet *A General Medical Service for the Nation* in 1930³⁵ and more recently in its *National Maternity Scheme*³⁶ published in 1936. Because of its 'financial requirements,' the BMA scheme had been rejected in 1930 as impracticable in a time of economic depression. Since the resources of the nation in 1936 were once again on the upgrade that objection had become less overwhelming.³⁷ The *BMJ* claimed that there was now growing impatience at the government's delay in bringing forward legislation that was so clearly necessary. The proposals for reform had been before the public for some years and there had been no expression of dissent from any quarter. Now that the scheme had been again 'recommended by an influential composite Committee for application in

³³ *Lancet*, ii, 1936, p. 27.

³⁴ *BMJ*, ii, 1936, p. 27.

³⁵ *Ibid.*, *Supplement*, i, 1930.

³⁶ *Ibid.*, *Supplement*, i, 1936.

³⁷ *BMJ*, ii, 1936, p. 27.

Scotland,³⁸ the *BMJ* hoped that there would be some parliamentary action. At the very least the extended general practitioner service could be introduced in Scotland as an experiment.³⁹

The necessary political will certainly existed in Scotland. Scottish members of Parliament created an early opportunity to voice their support for the Cathcart Report, only 12 days after its publication, during a meeting of a Committee on Supply on 14 July 1936.⁴⁰ The business of the day was to debate the motion that 'a sum not exceeding £2,207,766 ⁴¹be granted to His Majesty ...for the Salaries and Expenses of the Department of Health for Scotland' ⁴² for the coming year. It was made clear to members that while Scotland's health and health services were open for discussion, advocacy of new projects that would involve new legislation would be out of order in a debate on Supply. In spite of that necessary restriction it soon became evident that on that day it was the Cathcart Report that was uppermost in the minds of Scottish members of Parliament.

In opening the debate, Sir Godfrey Collins, the Secretary of State for Scotland, first gave a short review of the development of medical services in Scotland over the previous fifty years. His review was a brief but accurate reproduction of the history set out in the opening pages of the Cathcart Report. He went on to give a general account of the state of health of the people of Scotland. This was based entirely on the information

³⁸ Ibid.

³⁹ This had been suggested as a possibility by the Cathcart Committee (Report, p. 283).

⁴⁰ Sir John Brotherton, in *Improving the Common Weal* (op. cit., p. 77), has misread this debate. Speaker after speaker did, as he writes, speak mainly on the housing problem. This was appropriate since this was a debate on the Estimates for the coming year and the Secretary of State had stated that that spending would focus on housing. As will be shown, the wider issues of the Cathcart Report did not 'almost disappear from sight.' They were simply out of order on that day as was made clear at the beginning of the debate and again when the Under-Secretary of State closed. (*Hansard*, cccxiv, HC 14 July 1936, col. 2003.)

⁴¹ £1,250,000 had already been voted on account.

⁴² *Hansard*, 1936, op.cit., col. 1897.

gathered by the Cathcart Committee and was presented frequently in the same words. In projecting policy beyond the coming year, Sir Godfrey echoed what was perhaps the most innovative theme of the Cathcart Report, stressing that in future the Department of Health would give great importance to health education and would stress the need for every individual to take responsibility for the promotion and maintenance of his own health.

The Government, whether through the central authorities or the local government bodies, must do all they can to strengthen that concept in the mind of the public, but unless individuals take full advantage of the different Acts of Parliament their lives will not come up to the full standard that this House desires. As environment improves, as the standard of living increases, as the hours of labour are reduced Parliament will depend more and not less upon the individual to improve his own standard of health. Education is vital.⁴³

While the promotion of health services was of very great importance, the most pressing and immediate problem facing the Department of Health in 1936 was housing. Sir Godfrey announced that, in the distribution of funds in the coming year, priority must again be given to housing. But health problems were not to be ignored. Scotland's health statistics had improved since the beginning of the century, the death rate by 50%, the infant mortality rate by a 33 1/3 % and deaths from tuberculosis by 25%. However he added, 'I quote these figures in no spirit of complacency. I have made inquiries as to the progress being made in other nations and I am bound to say that a study of the health of other nations does not lead me to adopt any spirit of complacency when I study the health of our own people.'⁴⁴ Most disturbing of all was Scotland's high maternal mortality rate, 50% greater than in England. All previous efforts made to reduce 'that tragedy' had not been successful. For improvement, Sir Godfrey now looked to the Maternity Services (Scotland) Bill that was to come before the House a few days later. He also accepted the

⁴³ Ibid., col. 1899.

⁴⁴ Ibid., col. 1900.

verdict of the Cathcart Committee that the existing machinery of government, although it had done splendid work in the past, was 'not fully adapted to conditions today.'⁴⁵ The Committee had submitted proposals for reform. At a debate on Supply it would be out of order for him to announce the Government's intentions for legislation. But he assured members that his administration would act and 'in no party spirit.' 'In doing so we think we are interpreting aright the mind of Scotland.'⁴⁶

Even without a precise statement on legislation, the Scottish members understood the Secretary of State to have given the Cathcart Report his 'blessing.'⁴⁷ In the debate that followed, the authority of the Report as an assessment of the state of health in Scotland was universally accepted and its recommendations were welcomed. The Cathcart Report did not become an issue between political parties. For the Liberals, Sir Archibald Sinclair hoped that it would be read by everyone in Scotland; it was 'a masterly review of the present position of the health services in Scotland, and [makes] a series of imaginative, constructive and most valuable suggestions for a national health policy.'⁴⁸ J. C. M. Guy for the Conservatives, pronounced it 'a bold and comprehensive and far-reaching report'.⁴⁹ For the Labour Party, W. McL. Watson welcomed the Report 'as it opens the way for a fresh endeavour to establish a higher health service than we have enjoyed up to the present.'

Tom Johnston, the chief spokesman for the Labour Party, suggested that, in view of the importance of the matters raised in the Cathcart Report, members should limit their speeches to 15 minutes to allow as many as possible to take part in the discussion. In all, the unusually large number of 28 members of all parties were given an opportunity to

⁴⁵ Ibid., col. 1903.

⁴⁶ Ibid., col. 1904.

⁴⁷ Ibid., col. 1988.

⁴⁸ Ibid., col. 1908.

⁴⁹ Ibid., col. 1982.

speak.⁵⁰ Most members devoted their 15 minutes to housing. Housing was not only the main focus of the Supply motion ostensibly under discussion, it had been recognised in the Cathcart Report as the most important of the environmental factors influencing health in Scotland.⁵¹ Tom Johnston was in no doubt that housing was one of 'the reasons why our death rate is higher than in England or in the northern counties in Europe.'⁵² He cited the 'remarkable' information in the Cathcart Report on the 'appalling' living conditions in Scotland and the consequent damage to the development of so many children. During the debate members again and again referred to the persisting scandal of Scottish housing and the associated problems of overcrowding, poor sanitation and unreliable water supply. But every other subject of the Cathcart Report was also picked up for discussion by at least one member, e.g. hospital services (Sinclair, Horsburgh, McEwan); maternity services (McLean, McEwan); extension of the NHI Scheme (Moore); infectious disease (Leonard); insufficient food (Johnston), 'wrong feeding' (Boothby); safety of food (McQuiston); school milk (Cassells); health education (MacLay); physical training (Sinclair), birth control (Boothby), birth rates (McEwan); Highlands and Islands Medical Service (Boothby, Sinclair), Poor Law medical services (Guy). On every subject the recommendation made by the Cathcart Committee was approved. It became clear that within days of its publication the Cathcart Report had not only been accepted by Scottish members of Parliament of all parties as the ultimate analysis of Scotland's poor health but it would also be the touchstone in the process of organising for improvement.⁵³

⁵⁰ Labour, 12; Unionist 5; Conservative, 3; Liberal 2; Liberal National, 2; Labour Co-op, 1; National Liberal, 1; Conservative Unionist, 1; National Unionist, 1.

⁵¹ Cathcart Report, p. 142.

⁵² *Hansard*, op.cit., col. 1906.

⁵³ 'As a result of the discussion today, the Secretary of State will arise like a giant refreshed, and as far as the future is concerned, he will be a modern Wallace, cleaving his particular opinion into the minds of the Anglified Government Front Bench with which this House is faced at the present time.' Cassells (Lab.), *ibid.*, col. 1915.

Sir Godfrey Collins, who had commissioned the Cathcart Report, died only three months after its publication. He was succeeded, as Secretary of State, by Walter Elliot who was no less eager to promote the Report's recommendations.⁵⁴ Already at the opening of the new parliamentary session in November 1936, the King's Speech included a promise that a comprehensive effort was to be made to improve the health of the nation and that proposals would be submitted to Parliament in due course.⁵⁵ Replying on behalf of the Conservative Party, Florence Horsburgh welcomed this as an assurance of the Government's intention to bring forward legislation since the people of Scotland were now eagerly 'awaiting the Government's response to the Cathcart Report.'⁵⁶ A few months later, in presenting his Estimates for the Department of Health for Scotland, the Secretary of State assured Scottish members of Parliament of his intention to carry out some of the recommendations in the Cathcart Report immediately and that 'there are many more on which we will have to take action.'⁵⁷ Measures to improve health would therefore take up 'a fairly comprehensive section'⁵⁸ of the activities and resources of his administration. He assured members that the Scottish Office would 'by no means shelve' the Report. When Walter Elliot became Minister of Health in 1938, this pledge was kept by his successor, John Colville, and by the Secretaries of State who followed, notably Tom Johnston, co-author of the White Paper that followed in 1944 and Joseph

⁵⁴ Walter Elliot, a Glasgow medical graduate, had gained his DSc for his work on nutrition begun in Professor Cathcart's department at Glasgow University. He had been Parliamentary Secretary for Health in Scotland and later Under Secretary in charge of health at the Scottish Office, in all from 1924 until 1929. Collins had represented Greenock for many years, a town whose housing was notorious and which had been the site of the rent strikes in 1915. In promoting health Collins gave particular attention to housing. From a different background, Elliot was particularly interested in improving nutrition and medical services.

⁵⁵ *Hansard*, cccxvii, HC 3 November 1936, col. 9.

⁵⁶ *Ibid.*, col. 15.

⁵⁷ *Hansard*, cccxxv, HC 24 June 1937, col. 1403.

⁵⁸ *Ibid.*

Westwood, a member of the Cathcart Committee, who as Secretary of State presented the NHS Bill to the House of Commons in 1946.

The Cathcart Report was not presented at a propitious time for ambitious and potentially expensive reforms. The country's health services were already beginning to organise in preparation for the coming war. The country's financial resources were urgently needed elsewhere; on 17 February 1937 the Prime Minister was authorised by Parliament to borrow £400,000,000 for defence expenditure. Even with the full support of the Scottish Office, immediate implementation of those recommendations in the Report that required new United Kingdom legislation was not possible. In England and Wales they were not ready. There was not even the beginning of agreement on how hospital services should be organised for the long term; the antagonisms that would inevitably be aroused by fundamental reorganisation would be damaging to the process of organising the hospital services for war. In England, where medical practice was conducted in a more entrepreneurial spirit than in Scotland, the extension of the general practitioner service proposed by Cathcart was bound to be highly controversial. Discord had to be avoided at a time when the willing co-operation of general practitioners was required in preparing for emergency care of the massive number of civilian casualties expected in the coming war. Legislation for a fundamental reform of the health services in the United Kingdom was out of the question.

The Response

In June 1937, the Secretary of State announced that in Scotland the Department of Health would nevertheless press ahead with those of the Cathcart reforms that could be carried out under existing legislation or extensions to existing legislation.⁵⁹ Further reorganisation of the hospital services was still possible under the Local Government Act

⁵⁹ *Hansard*, June 1937, op.cit., col. 1403.

of 1929 and could be achieved with the support of the Commissioner for Special Areas in Scotland.⁶⁰ Some extension of the general practitioner services was already written into the Maternity Services (Scotland) Act. This Scottish Bill, which eventually became law in May 1937, had been more ambitious and wider in scope than that being prepared for England and Wales. The Scottish Bill had been ready since early 1936. However, fearing that publication of the Scottish Bill might create a demand for a similar extension of services in England and Wales, the Minister of Health had asked for the Scottish Bill to be delayed until his own Bill had passed the House of Commons.⁶¹ When the Scottish Act finally came into force it was soon further strengthened by the Registration of Stillbirth (Scotland) Act in 1938. Extension of the general practitioner service to cover thousands of young people was made possible by the National Health Insurance (Juvenile Contributors and Young Persons) Act of 1937. Improvement in the nutrition of children, better co-ordination of local authority clinic and environmental services could all be achieved under existing Scottish legislation.

From 1937 steady progress was made. The Cathcart Committee had reported that 200,000 houses had been built in Scotland since 1919. Surveys to discover how many were still required were being carried out under the Housing (Scotland) Act of 1935 but had not been completed in time for the publication of the Report. The number was subsequently estimated to be 250,000.⁶² These additional houses were needed principally to replace unfit houses and to put an end to overcrowding.⁶³ In all, the building programs submitted by Scotland's local authorities at 1936 anticipated that only 55,500 houses would be completed by 1941. Following the publication of the Report, the Secretary of

⁶⁰ The Special Areas Act of 1934 set up a Commission to co-ordinate and promote public works in the most distressed areas in the U.K. It was one of Sir Godfrey Collins' achievements that a separate Commissioner was appointed for Scotland.

⁶¹ PRO, CAB 23/82 36(36) 7th ; NAS HH61/787.

⁶² Cathcart Report, p. 143.

⁶³ *Annual Report of the Department of Health for Scotland*, 1937, Cmd. 5713, p. 18.

State urged local authorities to step up their building programs; 'I would remind the local authorities that the longer they delay in making their programs, judging from the internal situation of the country, the greater will be the problem in the future.'⁶⁴ He also announced that local authorities would no longer be allowed to build small houses of one or two rooms. In 1937 the number of houses completed by unassisted private enterprise increased to 7,593, the largest number since 1919. But in the same period local authorities had built only 13,341 houses, 17% less than in the previous year and the smallest number since 1932. The revival in the Scottish economy and the demands of the growing armaments industry had diverted building workers to other higher paid employment. There was also an absolute shortage of skilled men, bricklayers and especially masons. At the same time the cost of building materials had increased. Overall, building costs had risen steeply after 1934. Because of the volume of uncompleted work caused by this continuing rise in costs, many local authorities had decided to postpone all further housing contracts.⁶⁵ At the end of 1937, a temporary slight fall in building costs allowed local authorities at least to complete the backlog of tenders that had been approved in 1935 and 1936.⁶⁶

In 1938 three new Acts were passed which, along with the support of the Commissioner for Special Areas, gave new encouragement to house building. The Housing (Financial Provisions) (Scotland) Act provided additional financial support for slum clearance and for the relief of overcrowding; the Housing (Rural Workers) Act extended grants to private owners in country areas to enlarge and improve their houses; the Housing (Agricultural Population) (Scotland) Act gave financial support for improvements in agricultural workers' houses in an attempt to halt the drift of population from the countryside. For a time it seemed that the financial difficulties of the local

⁶⁴ *Hansard*, HC July 1936, op.cit., col. 1902.

⁶⁵ *Annual Report of the Department of Health for Scotland*, 1937, op.cit., p. 19.

⁶⁶ *Ibid.*, p. 27.

authorities had been overcome and by the end of 1938 a record number of houses had been completed.⁶⁷ But on the outbreak of war in 1939, 'because of the need for reserving labour and material for vital war work and for conserving the financial resources of the country,' local authorities were instructed not to enter into any new contracts or to begin work on houses contracted but not yet begun. Of 250,000 new houses known to be needed in 1936, less than 150,000 had been completed before the war.⁶⁸ This number was disappointing but it was almost three times the number envisaged before the publication of the Cathcart Report.

In their first discussions of the Cathcart Report, Scottish members of Parliament showed almost as much interest in the problems of water supply as in housing.⁶⁹ In 1937 the Department of Health reminded local authorities of the recommendations in the Report that there should be greater co-operation in making the best use of resources: 'many local authorities have in the past appropriated for their own use gathering grounds which would be the natural sources of supply for the adjacent area.'⁷⁰ The growing demand for water made co-operation even more essential. Local authorities were urged to make use of grants from the Special Areas Fund and those available under the Rural Water Supplies Act of 1934. In 1938 the Secretary of State was able to report that two regional schemes were already in place and that 71 other water schemes had been agreed. The special grant for the improvement in water supplies in the Highlands and Islands recommended by the Cathcart Committee had also been agreed.

On the reorganisation of the hospital services recommended in the Cathcart Report, the Secretary of State was able to report in 1937 that important progress had

⁶⁷ *Annual Report of the Department of Health for Scotland*, 1938, Cmd. 5969, p. 20.

⁶⁸ Approximately 70% by local authorities, 0.6% by Scottish Special Housing Association Ltd and public utility societies, the remainder by private enterprise.

Ibid., p. 21.

⁶⁹ *Hansard*, July 1936, op.cit., cols. 1898-1933.

⁷⁰ *Annual Report of the Department of Health for Scotland*, 1937, op.cit, p. 43.

already been made.⁷¹ The five regions to be served by Scotland's 474 hospitals (219 voluntary, 255 local authority) had been defined.⁷² In the process of reorganisation within the regions, only four of Scotland's 55 local authorities had not yet agreed to submit schemes for reorganisation and rationalising their hospital services. In reorganisation most had been achieved by those large authorities able to devise comprehensive schemes of their own. In other areas where 'unfortunately large burghs did not see eye to eye and would not combine in a joint scheme with a county council,'⁷³ progress had been much slower. Nevertheless, by 1938 a new fever hospital and a maternity hospital were nearing completion at Kilwinning in Ayrshire. Work had begun on a new general and maternity hospital and a fever hospital in Lanarkshire. A joint scheme for a new general hospital and a new fever hospital agreed by Dumbarton County Council and the Town Councils of Dumbarton and Clydebank was delayed only by difficulty in finding a suitable site. But in Greenock the local authority had rejected plans for a new municipal hospital in spite of an offer of financial support from the Commissioner for Special Areas; the local authority considered their medical services and hospital accommodation to be satisfactory, a judgement with which the Department of Health profoundly disagreed.⁷⁴ In most parts of Scotland rationalisation was under way. In Ayrshire the managers of the voluntary hospitals at Kilmarnock and Ayr were preparing plans for a joint hospital on a new site. In Kirkcaldy the Town Council and the managers of the voluntary hospital had agreed to

⁷¹ *Hansard*, June 1937, op.cit., col. 1430.

⁷² (1) Northern Region – Counties of Inverness, Ross and Cromarty, Sutherland, Caithness and Orkney. (2) North-Eastern Region – Counties of Aberdeen, Kincardine, Bamff, Moray and Nairn, and Shetland. (3) Eastern Region – Counties of Angus, Fife (north and east), and Perth and Kinross. (4) Counties of Midlothian, Peebles, Roxburgh, Selkirk, West Linton, Berwick, Clackmannan, East Lothian and Fife (south and west). (5) Counties of Lanark, Renfrew, Dunbarton, Stirling, Ayr, Dumfries, Kirkcudbright, Wigtown, Bute and Argyll.

⁷³ *Hansard*, June 1937, op.cit., col. 1403.

⁷⁴ *Annual Report of the Department of Health for Scotland*, 1938, Cmd. 5969, p. 115.

combine their efforts to improve local hospital services. This active, although uneven, pattern of development extended and continued across Scotland.

When hospital accommodation came to be surveyed during the planning of the wartime Emergency Medical Service it was judged to be adequate and could cope even with the expected additional load of emergency treatment of civilian casualties. But, by the measure set by the Cathcart Report, hospital services had not reached their target. There were still waiting lists. Nevertheless, significant progress had been made. The advantages of the regional arrangement of hospitals were generally recognised and, to a varying degree, within these regions co-operation had been established among local authority hospitals, between local authority hospital and voluntary hospital and between voluntary hospital and voluntary hospital.

In 1937 the creation of the extended general practitioner service recommended by the Cathcart Committee was also under way.⁷⁵ The National Health Insurance (Juvenile Contributors and Young Persons) Act of 1937 had added 133,500 people between the ages of 14 and 16 years of age as new panel patients on general practitioners' lists. The National Health Insurance (Amendment) Act of 1937 added those people employed by relatives who had previously been excluded from the NHI scheme. The increased level of employment in Scotland added a further 200,000.⁷⁶ By 1939 general practitioner services had been extended to include some 2,500,000 people - well over half the population - and the new general practitioner maternity service was available to every woman in Scotland.

Following the assurance given earlier by the Secretary of State⁷⁷ the Maternity Services (Scotland) Act, provided that any woman who wished to be confined at home could have the services of a medical practitioner and a certified midwife throughout her

⁷⁵ *Hansard*, June 1937, op.cit., col. 1403.

⁷⁶ *Hansard*, July 1939, op.cit., col. 1150.

⁷⁷ *Ibid.*

pregnancy, labour and lying in period. A consultant obstetrician was also to be available at any time at the request of the general practitioner. The Act laid down that the service was to be administered by the local authority. Where it had been introduced, the service was running smoothly and had proved to be popular. But by 1939 only 14 schemes were fully operational in Scotland's 55 local authority areas with a further 9 approved but not implemented. Some local authorities had been slow to interest themselves in the scheme but in most areas the delay was caused by difficulty in negotiating contracts with local general practitioners. These difficulties were eventually resolved after intervention by the Scottish Committee of the BMA and by 1941 the maternity service was operating across Scotland.

The lack of continuity of care and the lack of co-ordination, which had been the Report's chief criticism of the local authority health services, was partially corrected by the National Health Insurance (Juvenile Contributors and Young Persons) Act which provided a link between the school medical service and the general practitioner. The Act imposed a duty on the education authority to pass on the medical history of every young person (i.e. under 18 years) to the general practitioner taking responsibility for his or her care under the NHI scheme. The Department of Health supervised the necessary administration through the agency of the insurance committees and ensured that the information was recorded and passed on in a standard form. This new arrangement was made public in a BBC broadcast in April 1938.

No proposal for change was made in 1938 in the School Medical Service's primary duties of the medical inspection and the treating of minor disorders, but the Secretary of State did respond to the concern expressed in the Cathcart Report about the poor nutritional state of Scotland's children. The Cathcart Committee had recommended that the scheme, in which the Milk Marketing Boards in Scotland offered to supply milk

to school children, should be encouraged and developed.⁷⁸ The nutritional benefits of these milk supplements had been demonstrated by Sir John Boyd Orr and by Professor Cathcart.⁷⁹ In 1938 some 294,000 school children in Scotland were receiving a daily ration of 1/3 of a pint of milk but in some areas, especially in those areas where the milk was provided free, the number of children taking milk was in decline. The reasons were obscure. Since the Secretary of State was convinced that milk supplements during childhood would in time improve the general nutrition, not only of children, but eventually of the whole population, his immediate priority for the school medical service was to reverse this decline in uptake and to increase the daily milk supplement to the 7/8 of a pint as recommended by the Advisory Committee on Nutrition in 1937.⁸⁰

The Cathcart Committee had thought it probable that, although there was no widespread or gross malnutrition⁸¹ in Scotland, improved feeding would nevertheless raise the standard of health and physique of the population. In 1938 the Department of Health therefore welcomed the investigations being planned with the support of the Carnegie Trust. Sir John Boyd Orr was to make a dietary and clinical survey of 1000 families to study the effects of food on physical and psychological development and especially on the mental development of children. A preliminary investigation was to be carried out on 30 families in Aberdeen to establish appropriate methods.⁸² The Ministry of Labour was also investigating the costs of the diets of people across the United Kingdom. It was expected that these various investigations would take two years. The Department of Health delayed the formulation of a general policy on nutrition only until these investigations were completed.

⁷⁸ Cathcart Report, p. 191.

⁷⁹ *Hansard*, June 1937, op. cit., col. 1407.

⁸⁰ Annual Report of the Department of Health for Scotland, 1937, op.cit, p. 53.

⁸¹ In the 1930s 'malnutrition' was only diagnosed when the effects of nutritional deprivation were apparent on a single superficial inspection.

⁸² These families are currently being re-investigated by David Smith in Aberdeen.

The Cathcart Committee had laid great stress on the need for health education.⁸³ Its very detailed programme of health education in schools could not be put in place immediately. Changes to teacher training and revision of the school curriculum would take some years to accomplish and would require the agreement and support of the Education Department and the teaching profession. The programme also called for very considerable capital investment in the improvement and extension of school buildings and the construction of new schools. Financing the programme presented great difficulties for the local authorities. Nevertheless opportunities for initiatives in health education were not neglected. During the Empire Exhibition in Glasgow in 1938 the Under Secretary of State, Henry Wedderburn, presided at two full-day public sessions devoted to health education.

In the few years from the publication of the Cathcart Report until the outbreak of the Second World War, reform of the health services was carried on in Scotland with a vigour that was not equalled in England and Wales. Nevertheless the implementation of its recommendations was limited by the financial, administrative and political constraints of the time. In 1939 the pace of change increased. At the height of the Second World War Scotland's Chief Medical Officer assured an audience⁸⁴ in Edinburgh that it had been 'indeed fortunate' that, at the outbreak of war, the Department of Health had the advantage of a full and recent revue of the medical services in Scotland. The Cathcart Report 'was one of the best products of its kind and its scope extended over every aspect of the health services of the country.'⁸⁵ The Cathcart Report, with other factors '....such as the ease with which the country divides itself into regions suitable for hospital administration, the convenient size of Scotland as a national unit and the whole hearted support given to the Department of Health by local authorities, by voluntary hospitals and

⁸³ Cathcart Report, p. 103.

⁸⁴ Honeyman Gillespie Lecture given at Edinburgh Royal Infirmary, 30th July 1942.

⁸⁵ A. Davidson, 'The Contribution of the Emergency Medical Service to Medicine and Surgery in Scotland, *Edinburgh Medical Journal*, xlix, 1942, p. 555.

by all branches of the medical and nursing professions had combined to minimise the difficulties of providing a national hospital service for wartime purposes.' The Chief Medical Officer for Scotland saw this all-round spirit of co-operation, as a happy augury for the post-war reorganisation of the country's health services, 'which most people are agreed is necessary.'⁸⁶ Already in 1942 he was confident that Scotland had at hand something more than the scaffolding of a first class national hospital service.

The Emergency Hospital Service was conceived at a Cabinet meeting in September 1938.⁸⁷ The plans were drawn up by Walter Elliot, now Minister of Health, and John Colville, the new Secretary of State for Scotland. They had been warned to expect that, in Great Britain as a whole, civilian casualties from air raids might total 17,500 killed and 35,000 wounded every day⁸⁸ during the first two or three weeks of the war.⁸⁹ Since the existing hospitals could not hope to cope with such numbers it was proposed that huts should be constructed to accommodate additional hospital beds, 20,000 in England and the proportionately greater number of 6,000 in Scotland. In April 1939 these numbers were doubled. Under the Civil Defence Act, 1939 the Emergency Hospital Service in Scotland became the responsibility of the Secretary of State. In Scotland the service soon created an opportunity to make good some of the deficiencies identified by the Cathcart Committee and to expand the facilities for general surgery, orthopaedic surgery, general medicine and obstetrics.⁹⁰ New hospitals were built 'from the ground upwards', existing hospitals were upgraded, some small hospitals were extended by constructing hatted annexes, two hotels and a teacher training college were converted as surgical hospitals, 62 large private houses were converted as auxiliary

⁸⁶ Ibid, p. 554.

⁸⁷ I. Levitt, *The Scottish Office* (Edinburgh, 1992), p. 355.

⁸⁸ This forecast was based on the experience of the Spanish Civil War and the assumption that in modern warfare the bomber would always get through.

⁸⁹ PRO, CAB 24/284 CP (39) 77.

⁹⁰ Davidson, op.cit., p. 556.

hospitals and four convalescent homes were taken over.⁹¹ In all the number of beds in the Emergency Hospital Service in Scotland reached a total of 20,527. Of these, 16,574 were general hospital beds and 3953 were for convalescents. By 1942 the Emergency Hospital Service (EHS) had more than doubled the number of general hospital beds in Scotland.⁹² In addition to the many specialists who gave their services gratuitously, at its height the EMS employed 1149 doctors, 1277 nurse, 823 assistant nurses and 3,121 nursing auxiliaries.⁹³

In terms of general hospital services the Department of Health for Scotland was now the largest hospital authority in Scotland administering nine base hospitals and 66 auxiliary and convalescent hospitals. In line with the recommendations of the Cathcart Committee the EHS was organised on a regional basis. A Regional Hospital Office in each of the five Regions administered the EMS hospitals and co-ordinated the activities of the voluntary hospitals and local authority hospitals in the Region.⁹⁴ It had soon become apparent that the number of civilian casualties forecast for the first months of the war had been a wild overestimate. The doubling of the number of general surgical and medical beds in Scotland to accommodate vast numbers of casualties had quite unexpectedly created space for new services.⁹⁵ The Department of Health took the opportunity to establish special units for neurosurgery, peripheral nerve surgery, orthopaedics, maxillofacial surgery, effort syndrome, ophthalmic surgery and thoracic surgery. These units were distributed on a regional basis in seventeen separate hospitals. These were all new developing services that could never have found a space in the pre-war voluntary hospitals and would never have been contemplated in local authority

⁹¹ Ibid.

⁹² Calculated from the figures given by Dr Davidson, the Chief Medical Officer for Scotland. Ibid., p. 555.

⁹³ Ibid.

⁹⁴ Davidson, *op.cit.*, p. 556.

⁹⁵ Ibid.

hospitals. The Cathcart Report had suggested the framework in which these services were established and flourished, but the Cathcart Committee could not have planned directly for the accommodation of new specialist forms of treatment that had not been developed in 1936.

The Cathcart Report had noted that pulmonary tuberculosis was ‘still formidable, especially among adolescents and young adults.’⁹⁶ Since this is the age group most affected by the dislocations of war, the incidence of tuberculosis has often been accepted as one of the most sensitive indices of wartime conditions. Inevitably, after a marked decline over several years, the incidence of tuberculosis in Scotland increased sharply in the first years of the war.⁹⁷ Tuberculosis wards, which had become redundant in the 1930s, had been commandeered at the outbreak of war as accommodation for the expected vast number of casualties. When it became evident that they would not be needed for that purpose they were returned to the tuberculosis service to accommodate its increasing patient numbers.⁹⁸ The accommodation for the in-patient treatment of tuberculosis in Scotland was reviewed; 350 beds were added to the existing units and a new central unit was set up in an EMS hospital. Although the circumstances had not been foreseen by the Cathcart Committee, these developments followed the recommendations in the Cathcart Report that the institutional accommodation for the treatment of tuberculosis should be reviewed and that new centres for ‘modern treatment’ should be created.⁹⁹

Cathcart had proposed that centres should be created for the investigation of ‘disabilities of industrial origin’ and for treatment and rehabilitation of ‘any disabilities

⁹⁶ Cathcart Report, p. 206.

⁹⁷ *Health Bulletin*, ii, 4, 1943, p. 33

⁹⁸ ‘Tuberculosis in Wartime,’ *Annual Report of the Department of Health for Scotland*, 1942, Cmd. 6308, p. 14.

⁹⁹ Cathcart Report p. 206.

that may be found'.¹⁰⁰ This suggestion was taken up in the Clyde Basin Scheme.¹⁰¹ The areas chosen for this comprised the counties of Dunbarton, Renfrew, Lanark and the City of Glasgow; 44% of the total insured population of Scotland lived in this area and their pre-war sickness rate had been particularly high. Accommodation was made available in the EMS hospitals at Killearn (640 beds) and Law (1,280 beds) and in their associated convalescent homes. The necessary specialist skills were provided by the clinical staff of Glasgow University. General practitioners were asked to refer any of their patients, particularly young adult workers, who showed signs of a possible breakdown in health but did not yet suffer from overt organic disease. By 1944 almost 13,000 patients (52% female) had been referred. Most complained of tiredness, vague aches and pains or loss of appetite. A large number were suffering from anxiety states. Overall 44% of those referred to the Clyde Basin Scheme were found to be suffering from treatable disorders; 22% were admitted to hospital; 22% were admitted for convalescence.¹⁰²

Not all the capacity created for the Emergency Hospital Scheme was taken up by war casualties or by the new specialist services. Under an arrangement between the Department of Health and the British Hospitals Association (Scottish Section) first made in the summer of 1941 and extended from 16 January 1942, arrangements were made which allowed patients on the long waiting lists of voluntary hospitals - medical and surgical (but excepting chronic cases) - to be treated in EHS hospitals. No charge was made to the patient but, on his behalf, the voluntary hospital concerned made a payment that was uniform irrespective of length of stay.¹⁰³ In the first years of the scheme 5695 patients were admitted from voluntary hospital waiting lists.

Under the Civil Defence Act of 1939, the Department of Health was given powers to co-ordinate 97 voluntary and 29 local authority hospitals in addition to the EMS

¹⁰⁰ Cathcart Report, p. 262.

¹⁰¹ *Annual Report of the Department of Health for Scotland*, 1942, Cmd. 6372, p. 30.

¹⁰² *Ibid.*, p. 6.

¹⁰³ *Health Bulletin*, i, 2, 1942, p. 13.

hospitals under its direct control.¹⁰⁴ The operation of the total Emergency Hospital Scheme in each of the five Scottish regions became the responsibility of a Hospital Officer answerable directly to the Department of Health. In 1942 it was already clear that 'a striking feature of the Emergency Hospital arrangements was the co-operation between all interested hospital authorities and their staffs.'¹⁰⁵ An important aspect of that co-operation was the sharing of resources, with ready transfer of patients within the system according to patient needs and the availability of specialist skill and equipment. All hospitals in each Region were served by an Emergency Bacteriology Service set up under the Civil Defence Act establishing four central laboratories and nine subsidiary laboratories. An emergency Blood Transfusion Service, organised by the Department of Health at the outbreak of the war also served every hospital in Scotland. In March 1940 the Scottish National Blood Transfusion Association was constituted and assumed control of the service as a voluntary body subsidised by government grant (a percentage of approved expenditure).

In a very short time, with the creation of the EHS, the Department of Health for Scotland had become the hospital authority controlling the greatest number of general surgical and medical beds and almost all the new specialist services in Scotland. The Department of Health had also achieved an effective degree of functional integration of all three hospital systems in Scotland - the voluntary, local authority and Department of Health hospitals. In little over two years a working partnership had been created in which each hospital system had its own valued place.¹⁰⁶

¹⁰⁴ *Annual Report of the Department of Health for Scotland, 1942, op.cit.*

¹⁰⁵ Davidson, *op.cit.*, p. 559.

¹⁰⁶ In broad terms the local authority system provided hospital services for infectious diseases, mental illness and obstetrics; the voluntary system provided hospitals for general surgery and medicine. The Department of Health (EHS) provided space for the overflow from the voluntary hospitals allowing them to function efficiently and space for the new developing services.

Progress toward the creation of the comprehensive general practitioner service envisaged by Cathcart faltered in the early years of the war but did not come to a complete stop. The extensions to the National Insurance scheme after 1937 had created new opportunities for co-operation between the school health service and the industrial health service.¹⁰⁷ The general practitioner's entrée to the families of his insured patients was opened further by the new maternity service after 1937. In practice however it quickly became impossible for these opportunities to be fully taken up and fostered. Preparations for war had already begun as early as 1935 with the establishment in Whitehall of a Department for Air Raid Precautions. The Scottish Central Emergency Committee (SCEC) of the BMA was revived¹⁰⁸ in 1936 to organise general practitioners' part in ARP classes and anti-gas instruction. These duties added to general practitioner's already growing commitments and many doctors soon began to feel that their workload was becoming excessive.¹⁰⁹ In July 1939 the difficulties for general practice increased as the SCEC began to allocate doctors to the services or to civilian practice. Soon 33% of all doctors on the Medical Register in Scotland were serving in the armed forces.¹¹⁰ Since the SCEC had a duty to ensure that civilian general practitioner services were maintained, the proportion of general practitioners allocated to the armed services was less than that from the profession as a whole. Nevertheless the number of general practitioners in civilian practice was reduced by 18%.¹¹¹ Although the general recruitment to the armed services reduced the number of men on doctors' lists in Scotland by 13.9%, this was compensated by an increased number of women. During the war years

¹⁰⁷ The Secretary of State included these new relationships in the intended benefits of the National Health Insurance (Juvenile Contributors and Young Persons) Act. *Hansard*, cccxxxviii, HC 20 July 1938, col. 2234.

¹⁰⁸ First formed in Edinburgh in May 1915 and disbanded at the end of the First World War. J.R. Curry, *The Mustering of Medical Service in Scotland, 1914-1919*, (Edinburgh, 1922), p. 26.

¹⁰⁹ P. Bartrip, *Themselves Writ Large* (London, 1996), p. 220.

¹¹⁰ *Annual Report of the Department of Health for Scotland*, 1945, Cmd. 6661, p.16.

¹¹¹ *Ibid.*, p. 13.

the total number of persons entitled to the services of a general practitioner under the NHI scheme remained virtually unchanged. (But for a change in the income limit for participation in the scheme from £252 to £420 on January 1942, the number would have increased.) Taking account of the increased number of patients now able and obliged to pay for medical care, the overall number of patients to be served by the reduced number of general practitioners increased. At the same time demand increased; the new maternity service gradually came into full operation; the war-time public health services demanded doctors' participation; the longer hours of work of industrial workers obliged general practitioners to extend surgery hours late into the evening; doctors were also required to be available for casualty duties in emergencies. From 1941 there was a shortage of medical and surgical supplies. In 1942 a memorandum was issued by the Department of Health stressing the urgent need to limit prescribing to essentials and for a wider use of alternative drugs.¹¹² Throughout the war general practitioners were overstretched and under resourced.

War inevitably brought a decline in the health of the population.¹¹³ The volume of sickness among the insured population increased; on average each of these patients reported more illnesses.¹¹⁴ This was attributed to the 'long hours of work, changing shifts, transport difficulties, especially during hours of darkness and interference with normal arrangements for meals.'¹¹⁵ Most complaints were of minor illness¹¹⁶ but life-threatening illness also increased. Infectious disease became more prevalent in the population as a whole. The incidence of cerebro-spinal fever (meningitis) rose sharply in the first winter

¹¹² Ibid., p. 10.

¹¹³ Paradoxically the suicide rate fell from 102 per million at the height of the Depression to 76 during the war. *Health Bulletin*, ii, 1948, p. 29

¹¹⁴ *Annual Report of the Department of Health for Scotland*, 1942, Cmd. 6372, p. 11.

¹¹⁵ Ibid.

¹¹⁶ The Department of Health discontinued its central recording of incapacitating illness among the insured population in 1939.

of the war from a pre-war level of approximately 300 cases each year to a peak of 2,580 in 1941 and remained high throughout the war.¹¹⁷ Wartime living conditions increased the incidence of pulmonary tuberculosis from 4,657 in 1939 to 7,518 by the end of the war.¹¹⁸ The incidence of syphilis increased from a pre-war level of little over 2,500 each year to a war time peak of 5340; the number of cases of gonorrhoea, almost 5,000 cases annually before the war, rose to a peak of 6,500. Much of the increased burden of illness was in the non-insured population, particularly in the children. Deaths from diphtheria almost doubled in the year to 1940;¹¹⁹ in the west of Scotland there were persistent outbreaks of dysentery during 1941 and 1942; in the east there was an epidemic of paratyphoid in 1941; an epidemic of milk borne scarlet fever late in 1941 affected many parts of Scotland.¹²⁰ Deaths from these illnesses became somewhat fewer after 1943 but cases of dysentery and meningitis in children increased again in 1945.¹²¹ Outbreaks of smallpox affected both children and adults in Fife in 1942.¹²² In the nurseries that had become a new feature of the Public Health service during the war there were frequent outbreaks of diarrhoea caused by giardia lamblia. Nutritional problems were not entirely prevented in children; there were cases of scurvy in 1942.¹²³ In a health survey of mothers and children in Scotland's four major cities, 16% did not reach the standard of 'good.'¹²⁴ In all cities many children were found to be verminous and suffering from contagious skin diseases.¹²⁵

¹¹⁷ *Annual Report of the Department of Health for Scotland*, 1942, op.cit., p.32.

¹¹⁸ *Annual Report of the Department of Health for Scotland*, 1945, Cmd.6661, p. 6. The number of deaths in Scotland from tuberculosis during the war years was 26,528. (i.e. more than the 21, 942 British and Empire soldiers who died in the Boer War.)

¹¹⁹ *Health Bulletin*, i, 1942, p. 30.

¹²⁰ *Health Bulletins*, 1942- 52.

¹²¹ *Annual Report of the Department of Health for Scotland*, 1946, Cmd. 7188, p. 31.

¹²² There were 103 cases with 25 deaths.

¹²³ *Health Bulletin*, i, 1942, p. 31

¹²⁴ *Health Bulletin*, ii, 1943, p. 45.

¹²⁵ Glasgow introduced five mobile 'cleansing units' in 1942.

The official statistical indices recorded the sharp decline in Scotland's health from the first months of the war. In the first quarter of 1940 the death rate had already increased by 30% over pre-war levels. In the first 21 months of the war the estimated excess of deaths in Scotland was over 10,000 of which only 2,000 could be attributed to enemy action. The chief causes were acute infectious disease, tuberculosis, accidents and bronchitis and pneumonia. Only the new maternity services could claim improved results during the war; maternal mortality rate fell from 4.9 in 1938 to 2.7 in 1945 and infant mortality rate from 70 in 1938 to 53.8 in 1945.

The deterioration in health was attributed to the 'many and varied stresses' of war, and reached a peak in the winter 1940-41.¹²⁶ Thereafter there was a gradual recovery, beginning in 1942 and continuing until 1945. The improvement had been difficult to achieve and much of the load had fallen on a reduced number of general practitioners. In meeting their increased commitments, general practitioners had to endure an increase in working hours, disturbed sleep and difficulties in travel in the blackout. There had been no opportunity for retraining in the skills required for Cathcart's comprehensive general practitioner.

Nevertheless, wartime circumstances had carried general practice some way towards the model described in the Cathcart Report. The organisation of the country's medical services for war had brought the general practitioner into closer contact with local authority and hospital services and at the same time the GP had become, in some degree, the doctor to the whole family. Cathcart had found that general practitioners 'at present do not share what is called the preventive outlook'¹²⁷ and were not trained to advise on positive health. An Inter-Departmental Committee on Medical Schools appointed in 1942 recommended that, in future, medical students should be trained in the management of health as well as the diagnosis and treatment of disease. Its report

¹²⁶ *Annual Report of the Department of Health for Scotland*, 1945, Cmd. 6661, p. 4.

¹²⁷ Cathcart Report, p.167.

(Goodenough Report)¹²⁸ was a further step towards creating Cathcart's new role for the general practitioner. General practitioners in Scotland had no objection in principle to the new role proposed for them, but such an extension of their functions was clearly impossible in wartime. In *Improving the Common Weal*, James Hogarth has written that Cathcart's far-reaching proposals for general practice in 1936 had quickly 'run into the sand.'¹²⁹ It would be more accurate to say that in the first years of the war progress towards achieving Cathcart's goals became temporarily diverted by the extraordinary demands of the time. Cathcart's ideas for a new type of general practitioner survived to reappear in the *Report of the Medical Planning Commission* in 1942 (below).¹³⁰

Wartime conditions not only made new demands on the general practitioner, it extended the responsibilities of the public health services. Sir George Newman famously observed in 1907 that 'the centre of gravity'¹³¹ of the state's responsibility for the health was shifting from the protection of the population as a corporate whole to the promotion of the health of the individual. In the circumstances of war that shift was necessarily reversed. In the Second World War, rather than negating the progress made toward the implementation of the recommendations of the Cathcart Report, this reverse allowed the opportunity for further progress. Cathcart had recommended that, while 'there is undoubtedly a case' for local arrangements, 'where the circumstances are more or less uniform throughout the country' there should be a comprehensive sanitary code administered centrally which aims to 'secure uniformity'.¹³²

From 1939 the Department of Health assumed powers to become that central administration. The Department exerted its increased authority by the powers already vested in the Secretary of State for Scotland, by his additional powers under the Defence

¹²⁸ *Report of the Inter-Departmental Committee on Medical Schools*, HMSO, 1944.

¹²⁹ J. Hogarth, 'General Practice,' in McLachlan, op.cit., p. 182.

¹³⁰ *BMJ*, i, 1942, p. 743.

¹³¹ G. Newman, *The Health of the State* (London, 1907), p. 7.

¹³² Cathcart Report, p. 5.

(General) Regulations and (in the words of the Chief Medical Officer for Scotland¹³³) by exhortation. This exhortation was by official memoranda and, after June 1941, by the regular issues of the *Health Bulletin*, a publication launched by the Chief Medical Officer for Scotland and distributed at first only to Medical Officers of Health, but later to a much wider readership. The Department organised and strengthened measures to protect the health of the community from the hazards that could be expected in wartime. Local authorities were directed in measures to control infection. The provisions for vaccination against smallpox were reinforced; new schemes of immunisation against diphtheria and whooping cough were introduced.¹³⁴ Depots were established for the distribution of antitoxin against botulism. Schemes were arranged for the containment of outbreaks of scarlet fever and preparations were made in expectation of cases of typhus and rabies. Water supplies for all communities of over 3,000 were chlorinated. Measures were put in place to make milk safe, either by pasteurisation or by other means. Measures were introduced to reduce the contamination of air. In October 1943 guidelines were issued to ensure the best use of the limited supply of penicillin.¹³⁵ Efforts were made to maintain good standards of nutrition. Milk was made more easily available in schools and during holidays. School meals were no longer restricted to children of poor families or those who had to travel long distances to school and meals were provided at boys' and girls' clubs, and at community centres. From December 1942 cod liver oil and fruit juices were distributed to children.¹³⁶ These achievements were administered centrally and attained a large degree of uniformity.

¹³³ Written in a typescript circular that preceded the issue of the first *Health Bulletin*. (RECPE Archive).

¹³⁴ *Health Bulletin*, i, 2, 1941, p. 5.

¹³⁵ *Health Bulletin*, ii, 6, 1943, p. 78.

¹³⁶ Department of Health for Scotland, Circular 201/1942.

In addition to these traditional approaches to public health, in November 1941 the Department of Health launched a campaign on ‘Making the People Health Minded.’¹³⁷ As in the Cathcart Report, the usefulness of pamphlets, posters, public lectures, and even of the cinema, in health propaganda was treated by the Department of Health with considerable scepticism. ‘As a first step towards bringing the ordinary man and woman to a more health-minded attitude,’ Medical Officers of Health across Scotland were urged to follow the example of a scheme first launched in Edinburgh.¹³⁸ In this scheme members of the casualty services were trained to conduct discussion groups in their areas, acting ‘as missionaries in the new campaign and to encourage a common sense application of the basic principles of sound and healthy living.’¹³⁹ In 1942, in co-operation with the Scottish Education Department, plans were made to introduce hygiene as a subject in teacher training. Schemes of health education were gradually introduced in nursery schools, primary schools and post-primary schools on the model described in the Cathcart Report. More immediately, from 1943, classes on ‘Mothercraft’ and ‘Housewifery’ were included in the curriculum for girls in Scotland’s secondary schools.

From 1936 and into the early years of the war the Department of Health had pressed ahead as far as possible with the implementation of the Cathcart Report. In England and Wales there had been no corresponding drive for reform in the late 1930s and the early years of war had not brought such radical change and expansion in the hospital system. Although the structure of the health services had been relatively little affected south of the border,¹⁴⁰ in August 1940, the British Medical Association¹⁴¹ set up a Medical Planning Commission to ‘study wartime developments and their effects on the

¹³⁷ *Health Bulletin*, i, 2, 1941, p. 23.

¹³⁸ *Ibid.*

¹³⁹ *Ibid.*

¹⁴⁰ In England and Wales the number of ‘new’ hospital beds created by the EMS was relatively small and had much less impact on the overall hospital provision.

¹⁴¹ The work of the Commission was carried out by six committees that included representatives of the Royal Colleges and the Royal Scottish Corporations.

country's medical services both present and future'¹⁴² in the United Kingdom. The Commission defined the desired objectives for the post-war medical service as:

- a) To provide a system of medical services towards the achievement of positive health, the prevention of disease, and the relief of sickness.
- b) To render available to every individual all necessary medical services, both general and specialist, and both clinical and institutional.

In an interim report the Commission reiterated many of the criticisms of the existing medical services made in the Cathcart Report, quoting particularly Cathcart's censure of the lack of co-ordination of local authority services.¹⁴³ Quoting the MacAlister Report, the BMA Commission endorsed the principle that 'the organisation of the national health services should be based upon the family as the normal unit and on the family doctor as the normal medical attendant and guardian.'¹⁴⁴ Referring again to the Cathcart Report, the BMA Commission repeated its recommendation that the general practitioner should 'be concerned not only with diagnosis and treatment but also with the promotion of health and the prevention of disease.'¹⁴⁵ The BMA at last conceded that the 'National Health Insurance has proved a greater success than was anticipated.'¹⁴⁶ The BMA Commission, again in line with the Cathcart Report, recommended that the general practitioner service of the future should be based on the NHI Scheme. On hospital reform, the Commission accepted that all hospital services should be organised on a regional basis and commended the actions of the Department of Health for Scotland which, for several years, had 'advocated joint action for hospital purposes by local authorities and voluntary

¹⁴² 'Interim Report of the Medical Planning Commission', *BMJ*, i, 1942, p. 743.

¹⁴³ *Ibid.*, p. 744.

¹⁴⁴ *Ibid.*, p. 745.

¹⁴⁵ *Ibid.*

¹⁴⁶ In 1911 the National Health Insurance Scheme had been 'roundly condemned, by the BMA'. Bartrip, *op. cit.*, p. 153.

bodies over wide regions with teaching centres as their base.’¹⁴⁷ The BMA Commission recommended that the existing differences in the method by which voluntary and local authority hospitals determined which patients should pay for treatment should disappear. It was accepted that patients with adequate means should be required to pay but no firm recommendations were made as to how this should be arranged. The BMA Commission gave its greatest attention to possible models for the introduction of ‘Group Medicine and Health Centres’¹⁴⁸ that had been advocated in Scotland since the MacAlister Report in 1920 and again in the Cathcart Report.

The Medical Planning Commission produced an interim report in June 1942. No further report was issued. The Commission had been forestalled by the Government. On 9 October 1941, responding to a question in the House of Commons, the Minister of Health gave the first indication of the Government’s intentions for the post-war re-organisation of the country’s hospitals. (Policy for the general reform of health services had not yet been considered.) The future of the new hospital units created for the Emergency Hospital Scheme had ‘for some time been engaging the attention of the Government.’¹⁴⁹ The Minister of Health announced ‘certain broad principles’¹⁵⁰ that would form the basis of the Government’s future policy ‘as soon as may be after the war.’

It is the objective of Government...to insure that by means of a comprehensive hospital service appropriate treatment shall be readily available to every person in need of it. It is accordingly proposed to lay on the major local authorities the duty of securing, in close co-operation with the voluntary hospitals engaged in the same field, the provision of a service by placing on a more regular footing the partnership between the local

¹⁴⁷ Ibid., p. 745.

¹⁴⁸ Ibid., p. 748.

¹⁴⁹ *Hansard*, ccclxxiv, HC 9 October 1941, col. 1116

¹⁵⁰ Ibid.

authority and voluntary hospitals on which the present hospital services depend.¹⁵¹

He also indicated that it was the Government's intention to maintain 'the principle that, in general, patients should be called on to make a reasonable contribution towards the cost whether through contributory schemes or otherwise.'¹⁵²

The voluntary hospitals and 'the more specialised services at teaching centres'¹⁵³ were to continue, but it was clear that the dominant partner, in terms of size, was to be the local authority system and that it would absorb the EHS hospitals. This was a rational proposal for England and Wales where, in terms of size, the local authority system was already the major player, providing most of the hospital accommodation, including that for general medicine and surgery. In England and Wales the Emergency Hospital Service was, relatively, only a third of the size of that in Scotland¹⁵⁴ and had not been used so extensively to supplement the pre-war services or to foster the new specialist services; it could therefore be readily taken over by local authorities. But such a plan was clearly impractical for Scotland where the voluntary hospitals had always been the main suppliers of the core hospital services of general surgery and medicine and where the number of beds for these core services provided by the local authorities was now only a fifth of the number of beds available in EHS hospitals. Local authorities in Scotland, unlike those in England and Wales, had never been given powers to develop the ancillary services, even such basic services as out patient clinics and ambulance services, so necessary for any fully functioning general hospital.¹⁵⁵ Outside the major cities, local health authorities in Scotland had no experience in managing a modern general hospital.

¹⁵¹ Ibid.

¹⁵² Ibid., col. 1117.

¹⁵³ Ibid.

¹⁵⁴ PRO, CAB 24/284 CP(39) 77; PRO, CAB 27/659 EHO 1(39)2.

¹⁵⁵ Sections 181(2) (a) and 197 (1) of the Public Health Act, 1936 that provided these powers in England and Wales, did not apply in Scotland.

Nevertheless the Minister of Health had made it clear that the Government's policy was to apply to Scotland as well as to England and Wales, although 'certain differences in the Emergency Hospital Service and in the method of financing voluntary hospitals in Scotland are being given consideration.'¹⁵⁶

This new Government policy was in direct contradiction of the proposals in the Cathcart Report, which represented the consensus view in Scotland. Tom Johnston, the Secretary of State for Scotland, had now to examine the problems posed for Scotland by the Minister of Health's statement. He appointed Sir Hector Hetherington, Principal of the University of Glasgow, to chair a Committee on Post-War Hospital Problems in Scotland. Sir Hector hoped to avoid any unnecessary discord. In a letter to Tom Johnston on 23 December 1941, he wrote: 'In selecting members I have tried to avoid people who might be regarded as being too closely committed to the view of the Voluntary Hospitals or the Local Authorities.'¹⁵⁷ But even before his committee had begun its work he was warned by W.R. Fraser, Secretary of the Department of Health, that the soundings 'of the principal interests'¹⁵⁸ indicated that the longstanding consensus in Scotland was in some danger of becoming unsettled. Both the voluntary hospitals and the local authorities had been disturbed by the Minister of Health's statement and both were suspicious of the committee now being set up to interpret that policy for Scotland. Sir Hector, in a letter to the Secretary of State in December 1942, accepted that his task would be 'difficult and thorny.' It was not open to his committee to design a hospital service from scratch. 'The ground is already very well occupied with institutions of all kinds, many of them with years of distinguished service.' There was also 'the special and most interesting question of the future of the Government [EHS] hospitals of which, so far as I know, the

¹⁵⁶ *Hansard*, 1942, op.cit.

¹⁵⁷ DC 8/1101, Letter from Sir Hector Hetherington to the Secretary of State, 23 December 1941

¹⁵⁸ DC 8/1101, Letter from W. R. Fraser to Sir Hector Hetherington, 27 December 1941.

Department of Health has made a great success.'¹⁵⁹ In Sir Hector's view the options open to his committee had been severely restricted by the Government's decision announced by the Minister of Health on 9 October and 'I take it that by that decision we are bound.'¹⁶⁰ Later he found that his difficulties had been increased even further by the publication of the Beveridge Report which had 'added a certain definiteness to several points in the original statement by the Minister of Health.'¹⁶¹

The Hetherington Committee struggled to find an acceptable solution. After a year, in December 1942, Tom Johnston wrote to Sir Hector: 'I need hardly point out that the early publication of your Committee's report has now become a matter of importance, and I am sure the committee will be anxious to assist us by letting us have it as soon as possible.'¹⁶² On 14 April 1943 Johnston wrote again. He accepted that the Beveridge Report and various official statements about the post-war National Health Service were creating difficulties for the committee. 'But I am alarmed to think that we shall not have a report from you before August. Until I get your report I cannot go very far in discussions with the Voluntary Hospitals and I am afraid that consultations in England may get so far ahead that nothing which the Committee might say will make any difference... I am satisfied that a provisional or summary report could not fail to exert a greater influence on the discussions than would a full-length report in four months time.'¹⁶³

In June the Committee had still not reached a conclusion but had indicated that it had it in mind to recommend that the EHS hospitals should be handed over to the local authorities. In a letter on 7 June Tom Johnston asked the Committee to reconsider. 'Since I have become Secretary of State, I have been impressed with the great value which the

¹⁵⁹ DC 8/1101. Draft of letter from Sir Hector Hetherington to the Secretary of State, December 1941.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² DC 8/1101. Draft of Letter from the Secretary of State to Sir Hector Hetherington, December 1942.

¹⁶³ Ibid.

possession of State hospitals has been to us in facilitating experiments and pioneering work in various directions...These experiments have wide public and medical practitioner support, and their cancellation would be regarded as disastrous. I suggest that the difficulties of direct ownership by the Department of Health side by side with voluntary and local authority owned hospitals could easily be obviated by a sort of Public Corporation management of these state hospitals.'¹⁶⁴ On 21 June Tom Johnston gave more details of the Public Corporation he had in mind. He suggested

an organisation on lines similar to the Scottish Housing Association which consists of persons invited by the Secretary of State to form an association for a particular purpose, the association being registered under the Companies Act. It might consist of from six to ten members, probably with a paid chairman and it would of course have the necessary administrative, technical and clerical staff.

The business of the corporation would be to take over and administer such of the State's own hospital as were not required for other purposes. It would be subject to general directions from the Secretary of State, the most important of the directions no doubt being one which defined its scope in terms of pioneer and experimental work in certain fields.

The Corporation would be expected to co-operate, in the exercise of its functions, with other interests, particularly in such matters as the transfer of suitable patients, the joint use of certain consultants and specialists, etc. We should hope that suitable arrangements could be made with the Universities and other recognised Teaching Bodies for the use of material for both under graduate and postgraduate study.¹⁶⁵

Although the primary purpose of the Corporation's work would be to carry out pioneering work, it would also assist the other hospital services in introducing newly developed forms of treatment and provide assistance in reducing waiting lists. The exact financial arrangements would ultimately depend on the financial arrangements for the

¹⁶⁴ DC 8/1101. Letter from the Secretary of State to Sir Hector Hetherington, 7 June 1943.

¹⁶⁵ DC 8/1101, Letter from the Secretary of State to Sir Hector Hetherington, 21 June 1943.

country's hospital services as a whole, but the Corporation would be substantially supported by the National Exchequer and would not have to depend on charitable funds or become a charge on local rates.¹⁶⁶

The Corporation proposed by the Secretary of State could have been incorporated in Cathcart's recommendation that the hospital system should be based on the co-operation of voluntary and statutory hospitals and the public authorities. But the Hetherington Committee felt bound absolutely by the Government's stated policy for the United Kingdom. When its report was eventually published on 13 October 1943,¹⁶⁷ the Secretary of State's proposal of a Public Corporation was ignored. In flat contradiction of Tom Johnston's proposal, the report recommended that the experiment of state-run hospitals should be discontinued and that the Secretary of State, acting through the Department of Health, should refrain from active participation in general hospital administration. The Secretary of State must maintain his position of impartiality, essential to his function as arbiter between all other parties within the health care system. The EMS hospitals were to go either to the voluntary or to the local authority sectors on easy financial terms. This was thought to be in line with Government policy that was predicated on the assumption that, in time, voluntary hospitals would inevitably run into financial difficulties and, one by one, they would then be taken over by the local authorities. In the meantime, in Scotland, harmonious and effective partnership between the voluntary and local authorities was to be secured by setting up advisory councils in each of the five regions. These councils were to have equal representation from the two hospital systems with an independent chairman and a group of medical assessors to represent local medical opinion. The advisory councils would have some administrative authority including control of admission to hospitals. Unpaid medical service in the

¹⁶⁶ Ibid.

¹⁶⁷ *Report of the Committee on Post-War Hospital Problems in Scotland*, 1943, Cmd. 6472.(Hetherington Report)

voluntary hospitals would cease and there would be uniform salary scales in both hospital systems. A compulsory contribution scheme that would entitle patients to treatment and maintenance in hospital was to be set up as part of the social security scheme. Exchequer grants, administered by a Central Hospitals Fund, would be distributed to both voluntary and local authority hospitals to cover 60% of their expenditure.

The Report of the Committee on Post-War Hospital Problems in Scotland was a failure. It was late. Its financial arrangements were hopelessly complex; it was far from unanimous; it was disowned by its Chairman in a long and carefully argued Reservation of 12 paragraphs. More significantly, it was not well received by the Secretary of State. He presented its recommendations in a memorandum to Cabinet on 1 September 1943 without comment.¹⁶⁸ He had already let it be known in Cabinet and elsewhere, that he hoped to retain Department of Health hospitals within the hospital system in Scotland. He was well aware that, in the short term at least, committing them to the administration of the local authorities was an entirely impractical proposition. For almost every local authority in Scotland the administration of general hospitals was a closed book. Johnston was also in no doubt that any suggestion of consigning the country's hospitals to the care of the local authorities, even in the long term, would be bitterly opposed by the medical profession in Scotland. The submission of the Hetherington Committee was unhelpful and the long delay before it was submitted had weakened the position of the Secretary of State in Cabinet discussions on the future of the health services.¹⁶⁹

In his official history of the NHS, Webster refers to the 'authority' of the Hetherington Committee.¹⁷⁰ This exaggeration of its importance cannot be justified. Sir Hector Hetherington had chosen quite deliberately to exclude recognised authorities on hospital services from his committee. The Committee's proposal that voluntary

¹⁶⁸ PRO, CAB87/13 PR (43) 52; NAS HH101/2.

¹⁶⁹ DC 8/1101.

¹⁷⁰ C. Webster, *The Health Services Since the War* i (London, 1988), p. 65.

contribution schemes should be replaced by compulsory insurance arrangements - which according to Webster,¹⁷¹ was sufficiently important as to embarrass the voluntary hospitals in England - was part of a financial plan that had been rejected in principle and in detail by the Committee's chairman. The promotion of a regional organisation of hospitals in 1943, attributed by Webster principally to the Hetherington Committee, was no more than the latest reiteration of an intention that had been alive on Scotland since 1920. The Hetherington Report had no positive influence. It left the Cathcart Report still the undisputed expression of the preferred way forward in Scotland. It had failed to support an imaginative proposal by the Secretary of State for a new force in hospital services that would have been easily accommodated as a logical development within the general scheme proposed by Cathcart.

Even before the publication of the Hetherington Report all discussions of the future of Britain's medical services were given a new impetus and a new context with the publication of the Beveridge Report on Social Insurance and Allied Services. The welfare system devised by Beveridge was predicated on the assumption that it would be supported by a comprehensive national health service. In February 1943 the Government announced that it accepted that assumption. The Health Ministers (Ernest Brown, the Minister of Health, and Tom Johnston, the Secretary of State for Scotland) now embarked on staged process of planning for the National Health Service. In the first stage the Minister held informal and confidential discussions to test the feeling of interested parties, the local authority associations, the bodies representing the voluntary hospitals, the Royal Colleges and Royal Corporations. Groups, chosen from the relevant bodies, were set up to discuss in detail those aspects of a comprehensive service that would most affect them. These confidential discussions informed the Ministers of current views but the Ministers also made it clear that what they had in mind was not a revolution but a

¹⁷¹ Ibid., p. 47.

further stage in the long and continuous process by which the country had been steadily evolving its health services. The introduction of a single comprehensive service for all was to be regarded as the natural next development.¹⁷² The proposal for a new service was to be seen 'as part of a general evolution of improved health services which has been going on in this country for generations.'¹⁷³ In presenting a White Paper the Ministers drew attention to the various reports on the health services that had made significant contributions to the progress achieved in previous decades. The Dawson Report and the MacAlister Report were given credit for the proposal that the NHI scheme should be extended to cover persons of the same economic level as insured persons and dependants of insured persons. The Cave Report and the Sankey Report had proposed the establishment of central and local bodies to co-ordinate hospital services and had recommended that voluntary hospitals should be supported by exchequer grants. The Hetherington Report had dealt 'at some length' with various possible financial arrangements for future voluntary hospitals. The contributions made by the BMA and the bodies representing the voluntary hospitals¹⁷⁴ and the factual report published by Political and Economic Planning were all briefly noticed. However particular prominence was given to the Cathcart Report:

The report is too comprehensive in scope to lend itself to brief quotation, but it is one of the most complete official surveys of the country's health services and health problems yet attempted. The recommendations of the Committee have already been the basis of legislation in particular fields.¹⁷⁵

The Cathcart Committee had made many important recommendations within a national policy for promoting the fitness of the people and had assumed throughout that the

¹⁷² *A National Health Service*, 1944, Cmd. 6502, p. 5.

¹⁷³ *Ibid.*

¹⁷⁴ British Hospitals Association, King Edward's Hospital Fund for London, the Contributory Schemes Association.

¹⁷⁵ *A National Health Service*, op. cit., p. 75.

separate medical services must be integrated and that a co-ordinated medical service should be based, as far as possible, on the family doctor.¹⁷⁶

The White Paper reviewed the health services in the United Kingdom as they existed in 1944 in order to illustrate what had already been achieved towards the establishment of a comprehensive health service. All the services were reviewed very much as in the Cathcart Report. Of the services in Scotland most space was devoted to the Highlands and Islands Medical Service, 'a unique effort in co-operation between the State and doctors in private practice which has revolutionised medical provision in the area.' The White Paper set out in some detail how this co-operation had been achieved and maintained. It also drew attention to the vital contribution to the success of the HIMS made by the 'similar improvement that has been effected by the nursing services.' Since its foundation the service had developed 'beyond the primary essentials, medical and nursing' to provide general medical and surgical hospital services, and tuberculosis and other specialist services. In 1944 there was in place a 'comprehensive service which obviates the transfer of many patients to the mainland' but also included an air ambulance service when transfers were necessary. The success of the HIMS had been achieved at an annual cost of 'just under £100,000'.¹⁷⁷

In the White Paper the Ministers felt that it was necessary to make clear what was meant by a comprehensive service. The service was to be comprehensive in two senses – first it was to be available to all and second it was to cover all necessary forms of health care from the care of minor ailments to the care of major diseases and disabilities. It was to include the ancillary services of nursing and midwifery 'and of the other things which ought to go with medical care.'¹⁷⁸ Advice and attention - from family doctor to specialists and consultants of all kinds - must cover the whole field of medicine, at home, in the

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ Ibid., p. 9.

consulting room, in the hospital or the sanatorium or wherever else was appropriate. The service was to be free for all, apart from possible charges for certain appliances. In the 'comprehensive' service there were to be temporary exceptions. A dental service was unquestionably a proper aim. Unfortunately there were not, and would not be for some years, enough dentists in the country to provide it. The inclusion of mental health services would also be difficult until the law on lunacy and mental deficiency was re-drawn but the Ministers aimed to reduce as far as possible the distinction between mental ill-health and physical ill-health.

In the White Paper the Ministers set out what they believed to be the best means of bringing the service into effective operation. The scope and objects of the service were to be the same in Scotland as in England and Wales but there would necessarily be certain differences in method and organisation. Allowance would need to be made for the geographical distribution of Scotland's population - 80% were concentrated in the 17% of the area of the country across its central 'waist' while 32 of the 55 local authority areas had populations less than 50,000. This alone called for differences in structure. Central responsibility would rest with the Secretary of State advised by a Central Services Council and with a Central Medical Board as the employing body of the general practitioners (as in England and Wales). However, the proposed health centres would be administered centrally by the Secretary of State. While the units of organisation in England and Wales would be the counties and county boroughs, in Scotland services would be arranged in five administrative regions.

The White Paper was issued for discussion and for the formulation of a Bill creating a National Health Service. In England and Wales, differences that had been unresolved for years led to acrimony and delay. In Scotland there was a long-standing consensus that had found its expression in the Highlands and Islands Medical Service, in the Cathcart Report and in the White Paper itself, and Scotland already had thirty years experience in administering a comprehensive health service.

CHAPTER TEN

CONCLUSION

There are many misconceptions about the origins of the National Health Service that are still widely held and have not been re-examined even by specialist historians. This thesis has attempted to address one of these common misconceptions, the notion that the National Health Service was created suddenly in the reconstruction of the country's institutions after the Second World War and that against much resistance a British scheme was thrashed out, that required only minor adaptations to make it suitable for application in Scotland. Although this idea has been perpetuated by historians it is not supported by the facts. The concept of a national health service had evolved over decades and by the mid 1930s a scheme for a national service already existed in outline and had wide support in every part of Britain. While that scheme developed unopposed into the National Health Service in Scotland it had to be considerably modified to accommodate powerful vested interests before a final scheme could be agreed for England and Wales.

The story of the creation of the National Health Service begins with the publication of the Report of the Royal Commission on the Poor Law and the Relief of Destitution in 1909. The Majority Report favoured the *status quo*, but it was the Minority Report that proved to be more significant. It signalled the beginning of an expansion of the state's contribution to the care of the sick. For many generations the state had accepted direct responsibility, under the Poor Law, only for the treatment of sick paupers. But by the end of the nineteenth century the industrialisation of the country and the uncontrolled urbanisation of its people had created a new poor, made up of large numbers not absolutely destitute and still unwilling to give up full citizenship in order to find help under the Poor Law. This new poor did not have the financial means to access medical care whatever their needs. Living in appalling overcrowded and insanitary housing, a large part of the working population in

Britain's industrial towns and cities - those who survived infancy and had not died of a contagious disease- were stunted in their growth and development by lack of sunlight, lack of space and lack of proper food, made worse in many cases by a surfeit of alcohol. The full extent of the resulting disease and disability remained largely hidden from the more prosperous and influential members of society until it was exposed, to great general alarm, by the recruiting officers looking for fit army recruits for the Boer War. Over the next fifty years the problem was not solved. The same evidence of deprivation was seen again in the recruits for the both World Wars and, most disturbingly, in the children evacuated from the cities in 1939. When the Second World War came to an end, although the problem still remained, in Scotland a start had been made towards its solution.

The problem of social deprivation in Scotland was greater even than in the worst parts of England. Industrialisation and urbanisation had come later, had been more sudden and intense and had affected a larger proportion of the population in Scotland than elsewhere in Britain. Already in the 1840s William Alison and Robert Cowan had shown that the chief cause of misery in Scotland's cities was poverty. Nevertheless in the nineteenth century the Poor Law in Scotland offered little assistance to the families of the able-bodied, no matter how much in need, and the Church of Scotland was more concerned with the spiritual well-being of the poor than in the physical conditions in which they lived. In the course of the nineteenth century, the Industrial Revolution and Scotland's Economic Miracle had created a proletarian society and established a culture of poverty.

When New Liberalism at last turned attention to the need for social reform it was the very size of the problem of poverty and deprivation in Scotland that determined that Scotland would inevitably find its own path towards recovery. In a small country no one could be unaware of a problem that was so massive and all pervasive. The country's administration could not shut its eyes to a problem that touched every aspect of the country's affairs. The civil servants, the doctors, and politicians who had to deal with the resulting distress and sickness were drawn from a

part of society that was not far removed from the distressed working class and could not easily walk away. In Scotland there was no resident society of the wealthy and influential to tempt the medical profession to confine their ambitions to social success in entrepreneurial private practice and ignore the condition of the masses. Only a minority of doctors could establish a viable practice in which the clientele was entirely middle class and the vast majority of the medical profession were only too aware that the majority of those most in need of their services were not, and would never be, able to pay. It was predictable that when the Minority Report of the Royal Commission recommended that the state should extend its medical and welfare services to a much larger section of the working class, support in Scotland was virtually unanimous among the medical profession and, according to the *Edinburgh Medical Journal*, among the general public.¹ When New Liberalism began to press for social reforms, in Scotland there was already a gathering consensus of support. Everyone was aware of the problem of social deprivation, the severity of the problem was generally regarded as intolerable and there were no powerful vested interests to be overcome. The medical profession in Scotland did not regard public service as innately inferior to private practice; it had never been possible for local authority hospitals to rival the services provided by the voluntary hospitals, the teaching hospitals had never set themselves apart from the general voluntary system and the local authorities were already struggling to fulfil their existing obligations and had no wish to take on services of which they had no experience and become the sole agent of health care.

The movement for reform was assisted, if not by a whole-hearted call for Home Rule, at least by a growing sense of nationalism and a feeling that Scotland was not 'getting its fair share.'² The creation of a Scottish National Insurance Commission and, a few years later, a Board of Health outside the direction and control of the Ministry of Health were responses to that new sense of nationalism. In 1919 the

¹ *Edinburgh Medical Journal*, NS iii, 1909, p. 14.

² Sir Godfrey Collins, quoted in Chapter One.

Scottish Board of Health was drawn from the membership of health organisations which had no reason to regard each other as rivals and found that consensus was to their mutual advantage. The Minutes of the Board show every evidence of a common sense of purpose and contain no record of any serious difference of view.³ As the instrument of its policies the Board created a new welfare bureaucracy to administer its policies from Edinburgh. In *The Autonomy of Modern Scotland*, Lindsay Paterson has described the significance of a separate bureaucracy for Scotland:

The argument is not that Scotland had control over its own legislation, (although it could influence that)... the politics that mattered were those of the bureaucracy, in the sense that the autonomy and distinctiveness of any country in the mid twentieth century rested more on the way its bureaucracy interpreted legislation than on the legislation itself. Scotland had its own welfare state bureaucracy.⁴

In the years of economic slump and the great Depression in the 1920s and into the 1930s, as the need for improved social welfare and more effective health services had become all too obvious in Scotland, it became equally obvious in some parts of England and Wales. However, for central government in London the imperative was the need to contain public spending during the period of acute fiscal difficulty. On social reform 'a consensus...existed between Stanley Baldwin and Ramsay MacDonald: a consensus to prevent anything unusual from happening.'⁵ But while central government in London did not adopt 'a more positive and purposeful'⁶ attitude until the war, a devolved welfare bureaucracy in Scotland was carefully nurturing a consensus that found its expression in the Cathcart Report in 1936.

There are many who believe that the creation of the National Health Service began with the publication of the Beveridge Report in 1942 and ended with the

³ The Minutes of the Scottish Health Board were read while they were in the possession of Miss Elizabeth String. They are now in the National Archive of Scotland.

⁴ L. Paterson, 'Scottish Autonomy in the UK Welfare State,' *The Autonomy of Modern Scotland*, (Edinburgh, 1994), p. 103.

⁵ P. Addison, *The Road to 1945* (London, 1994), p.14.

⁶ Ibid.

compromises successfully contrived by Aneurin Bevan in 1946. Those more aware of the historiography of the creation of the National Health Service in England and Wales may see the Dawson Report, frustrated for over two decades, as the inspiration for the sudden activity after 1942. But the history of the creation of the National Health Service in Scotland is the story of a consensus steadily built up and nurtured over the years by a Scottish Board of Health Board and a Department of Health for Scotland that were independent of the Ministry of Health and uninfluenced by the power struggles in London. When the Scottish Board of Health was taken over by the Department of Health for Scotland in 1929, the Department was also answerable to the Scottish Secretary and independent of the Ministry of Health. It continued the separate policies for Scotland initiated by the Board but now supported by a stronger and more effective welfare bureaucracy. Over the years, progress was guided by a number of reports commissioned by the Board of Health and by the Department of Health. The most influential, and the last before the creation of the NHS, was the Cathcart Report.

The Cathcart Report reviewed social conditions and the state of Scotland's health in 1936, not in the context of the Depression – the context in which it had been appointed – but in the light of the progress that had been achieved since the previous century. This made it possible to make an optimistic appraisal. It also made it possible to avoid controversy. The Cathcart Committee aimed to present a health policy that would require the future support of central government and the active co-operation of all the health bodies then operating in Scotland and, if the policy was to be implemented in Britain as a whole, the health organisations in England and Wales. Too stark an account of social conditions and the state of health of the population might unhelpfully seem to contradict central government's claim that the existing services had proved entirely adequate during the slump and the Depression. Too fierce a critique of the existing services might alienate those whose co-operation would be required in the future and provoke recriminations that would disturb the consensus that had been established in Scotland over very many years. For the

Cathcart Committee's scheme to succeed consensus was all-important. It was unfortunate that, in carefully avoiding controversy, the Cathcart Report presented an account of social conditions and health in Scotland that, although accurate, was limited and did not alert the planners of the National Health Service to the full extent of the problems that would face the new service in 1948.

The Cathcart Committee was not a disinterested panel of management consultants. It was made up of members with first hand experience of Scotland's health services and aware that they had conspicuously failed to secure for the people of Scotland the standard of health enjoyed by most other countries of Western Europe. The policy they set out was not shaped by any abstract ideology or as part of a party political agenda. The health policy it put forward was the consensus view of members of the organisations - central government, the local authorities, the insurance commissioners, the trade unions, the medical profession and the universities - that were in a position to correct the health problems that had been allowed to take root in Scotland between the wars.

The policy proposed by the Cathcart Committee was enlightened and appropriate to its time. In 1936 it set out many of the essential features of the health services that, in 1942, Beveridge had in mind as an essential support in his scheme for social security, and that were later adopted in the National Health Service in 1948. But over these years some important aspects of Committee's scheme had become outmoded.

When the Cathcart Committee began its work in 1933, it would have been judged irresponsible to subordinate prevention to treatment. The concept of prevention had begun to widen and was no longer confined to the traditional measures to protect whole populations by programmes of sanitary measures and schemes of isolation. Medical science was opening up a new and promising future in the promotion of the health of the individual. The new science of nutrition could prevent common diseases such as scurvy, chlorosis, and rickets and improve health in ways not yet fully understood; immunology provided protection of the individual from

diphtheria, tetanus and botulism as well as smallpox; endocrinology could extend the lives of those suffering from diabetes mellitus, pernicious anaemia and thyroid deficiency.

Active medical treatment on the other hand was still essentially symptomatic and palliative. Specific remedies were almost unknown;⁷ medical care fell far short of medical cure. It was only in the 1930s that curative treatments became conceivable. In 1927 Ehrlich had found that dye, later called Prontosil, could cure streptococcal infections in mice; the first clinical trials in humans were carried out in 1935. The results of the trials were not widely known and their full significance was not yet understood when Cathcart reported in 1936. It was only later that it was discovered that the active principle of Prontosil was sulphonamide, a substance first synthesised 30 years before now lying unused in the stores of industrial chemists and immediately available. In spite of their unpleasant side effects, sulphonamides were soon being hailed as wonder drugs: 'The general public appears to regard these drugs from one of two aspects: either as a veritable elixir of life which no one can neglect to employ or as a kind of last rite in a desperate emergency.'⁸

In 1938 work had begun on the production of penicillin. Clinical trials carried out in 1940-41 showed it to be more potent than sulphonamide and free of side effects. When the Beveridge Report was published supplies were still controlled by the Medical Research Council and penicillin had not been yet been released for use in civilian practice. But its seemingly miraculous effect in the treatment of war casualties was already becoming widely known. The therapeutic revolution had begun; a modern and thriving pharmaceutical industry offered the prospect of more antibiotics and even more miracle cures. Cathcart's priorities had been by-passed.⁹ It no longer seemed so necessary to prevent disease or for each individual member of

⁷ At the beginning of the century a doctor's pharmacopoeia would generally consist of opium, an emetic, a laxative, a diuretic, a carminative and quinine.

⁸ *Lancet*, ii, 1942, p. 706.

⁹ It seems highly probable, even inevitable, that Cathcart's priorities in health policy will be restored in the 2000s.

society to learn to protect his own health. It now seemed reasonable to look for an easy cure from the free health care system promised by Beveridge rather than to the long-term discipline of prevention advocated by Cathcart.

Beveridge failed to foresee the increase in costs to the state that would come with the introduction of free medical care in a demand led system. The Beveridge Report's section on the 'Social Security Budget' included the surprising projection that the cost of health care under his scheme would remain stable.¹⁰ In retrospect this projection can be seen as wildly improbable. It can only be explained by Beveridge's belief that the existing health services, in spite of their defects and anomalies, were already efficient and 'unmatched and scarcely rivalled in any other industrialised country.'¹¹ It may have seemed to Beveridge that it remained only to make the existing unrivalled health services available to everyone. He must also have assumed that by abolishing want, his scheme of social welfare would reduce the total burden of disease to a level that could be easily contained without major outlay on medical services. The Cathcart Report, the most up to date assessment of health and health services had indeed claimed that 'economy was to be found by reducing the burden of ill-health and by securing that all measures for this purpose yield their maximum results.'¹² But in 1936 the Cathcart Committee could not have foreseen the revolution in medical science that would bring new ways of curing rather than preventing disease – but at enormously increased cost. In 1942 the full implications of that revolution were still not obvious to Beveridge. His consequent failure to recognise the size of the financial burden his assumption of free treatment would place on the state's medical services was not corrected in the White Paper in 1944 or in the National Health Service Bills.

The Cathcart Committee's policy was even more severely undermined by the social revolution spearheaded by Beveridge. The relationship between state medical

¹⁰ Beveridge Report, p. 33.

¹¹ *Ibid.*, p. 38.

¹² Cathcart Report, p. 289.

services and society in Britain was to be fundamentally altered in a way that Cathcart did not anticipate. The new state medical services introduced in the years of the New Liberalism had been promoted by members of an educated minority who felt a moral duty to plan and organise a new and rational social order for the poor and less educated majority.¹³ Health services reached the masses as the beneficence of government and its administrators. In the 1930s the Cathcart Committee still assumed that health services would continue to be provided for the mass of the population under the altruistic control of the administration. But the publication of the Beveridge Report brought a dramatic change in public attitudes to health services. Beveridge had promised free medical services for all. He had not thought it necessary to set a limit to what was to be free and to be freely accessible to all. It could only be assumed by the public that whatever medicines were available and whatever specialist treatments were possible were to be at their command. It was an inevitable consequence of the adoption of the Beveridge Report that the administration must resign control over what was to be provided. Its role would now be to provide, rather than to determine and shape, state medical services and to provide them according to the priorities of the public. This was unforeseen by Cathcart in 1938 and by Beveridge in 1942 and was still not fully understood when the National Health Services were launched in 1948. The experience of the Highlands and Islands Medical Service since 1913 had passed unnoticed. The service provided in the Highlands and Islands was free, comprehensive and demand led. The Highlands and Islands (Medical Services) Board had soon discovered that while the demand for routine and familiar treatment in general practice was finite the demand for new, advanced and expensive specialist services was infinite. The Cathcart Committee had found that the HIMS had been 'an outstanding success and is universally approved.'¹⁴ But before 1936 the possibility of

¹³ It was still assumed that medical services provided by the state would be supply led. 'We concluded that we should soon be able scientifically to deal with Disease without pandering to the patient.' Sir Auckland Geddes, *A Voice from the Grandstand: A Dissertation to the Royal Medical Society* (Edinburgh, 1937), p. 2.

¹⁴ Cathcart Report, p. 232.

a comparable free and comprehensive health service for Scotland had not been contemplated. The lessons of the HIMS seemed irrelevant. Their relevance to proposals of the Beveridge Report went unnoticed and remained unnoticed even after 1948. In the National Health Service, governments made an unlimited commitment to service. Blind to the revolution in medical science and the cost of the new treatments that would be demanded by the public and unaware of the amount of disease and disability to be treated, the government also accepted an unlimited liability to expense.

Throughout the planning of the National Health Service the Cathcart Report was still the most comprehensive and the most recent review of health and health services in Britain. In the circumstances, that review was surprisingly benign. The motives of the Cathcart Committee are understandable. It seemed necessary to preserve consensus and avoid arousing the hostility of central government by declining to take part in what Webster has described as the Government's attempt to prevent 'ammunition for critics... from being made public.'¹⁵ Nevertheless, in retrospect it was a surprising and in the end an unfortunate tactic. As has been shown in previous chapters, there was ample evidence - not only on the writings of Edwin Muir,¹⁶ George Orwell,¹⁷ MacGonigle,¹⁸ John Boyd Orr¹⁹ and many others, but also in the official reports of the Department of Health for Scotland and the Registrar General for Scotland - of the true severity of social conditions and the resulting poor health, especially in Scotland. The Cathcart Committee recognised the existence of health problems in Scotland and identified the prevailing social conditions as the principal cause but planning for the future required a reliable analysis of the existing problems. In its portrayal of social conditions and the health of the people, the Cathcart Report was politic rather than exact and while it pointed the planners of the National Health

¹⁵ C. Webster, 'Hungry of Healthy Thirties?' *History Workshop Journal*, xiii, 1982, p. 112.

¹⁶ E. Muir, *Scottish Journey* (Edinburgh, 1935)

¹⁷ G. Orwell, *The Road to Wigan Pier* (London, 1937)

¹⁸ G. C. M. M'Gonigle and T. Kirby, *Poverty and Public Health* (London, 1936)

¹⁹ J. B. Orr, *Food Health and Income* (London, 1937)

Service in the right direction it failed to predict the size of the problems that would face the new service in 1948.

The Cathcart Report proved to be a more certain guide for the organisation of the National Health Service in Scotland. It was Cathcart's chief criticism of the health services of the 1930s that they were uncoordinated, 'suffering less from overlapping than from the gaps they leave in the attack...on illness and death.'²⁰ Cathcart recommended that the necessary co-ordination should be achieved by the state but through an organisation based on the existing general practitioners and their supporting services rather than by the creation of a new comprehensive state medical service operated by the local authorities. This would provide 'a flexible structure so that, at any time and according to circumstances, effort may be directed where it would yield the best results.' The Cathcart Committee hoped to retain and encourage 'that complex of motives that inspires the services as they now exist.'²¹ It was central to Cathcart's plan that these existing services should be encouraged to co-operate in integrating their services more effectively under the direction of central government in Scotland. It was also intended that these integrated services should be of uniform standard and equally available across Scotland. It was in its emphasis on integration and even distribution of services that the National Health Service (Scotland) Act differed from the equivalent Act for England and Wales. The differences in the Acts as published were few in number but were enormous in their impact on the ethos and functioning of the distinctive services they created.

Cathcart stressed that it was imperative that all hospitals should co-operate in order to ensure a proper allocation of patients to the institutions most suitable to their needs.²² Local hospitals in each area should be able to look to central hospitals fully equipped for specialist services and there should be free exchanges of services between central and local hospitals in order to maximise the use of the facilities

²⁰ Cathcart Report p. 313.

²¹ Ibid., p. 25.

²² Ibid., p. 236.

available in each.²³ Such integration of hospital activities would also make it possible to extend medical teaching over the whole range of hospital practice. In 1947 the National Health Service (Scotland) Act set up five Regional Hospital Boards across Scotland to ensure the integration of hospital and specialist services in every part of Scotland. The Act also laid down that 'the Secretary of State shall secure as far as is practicable, that the provision of the said services in the area can conveniently be associated with a university having a school of medicine.'²⁴ The Act also provided that each Regional Hospital Board should have a Medical Education Committee to advise 'on the administration of the hospital and specialist services in the area so far as relating to the provision of facilities for undergraduate or postgraduate clinical teaching or for research.'²⁵ Each university was to be represented on the Boards of Management of all the hospitals within its area.

This unified hospital system was not introduced in England and Wales. On 5 October 1945, the new Minister of Health, Aneurin Bevan, presented a paper to Cabinet²⁶ outlining his plan for the solution to what had emerged as the major problem in the structuring the National Health Service – the need to reconcile the competing hospital services in England and Wales. He proposed to nationalise the nation's hospitals;²⁷ only the teaching hospitals were not to be taken over. A week later he modified his proposal; teaching hospitals were not to be excluded completely but 'special provision should be made for them within the scheme.'²⁸ The decision to make this special provision for teaching hospitals was not the result of any formal negotiation with the leaders of the medical profession.²⁹ But following the publication

²³ Ibid., p. 237.

²⁴ National Health Service (Scotland) Act, Part II, 11(1).

²⁵ Ibid, Part II, 11(3).

²⁶ PRO CAB 21/2032 (CP (45) 205).

²⁷ This possibility had been considered earlier by English and Scottish officials but rejected since the hospitals seemed already irreversibly evolving toward municipalisation. C. Webster, *The Health Services Since the War* i (London, 1988), p. 83.

²⁸ Ibid., p. 85.

²⁹ 'There was much opposition from the consultants in the South. I don't know who inspired him, but Nye Bevan bought them off by giving them the part-time basis and

of the White Paper the teaching hospitals and their consultant staff had made it clear that they would remain opposed to nationalisation unless given a much greater share in the planning and control of the new service.³⁰ It may be assumed that Bevan's undertaking to make 'special provision' for the teaching hospitals helped to cement the good relationships established between Bevan and leading London consultants at social gatherings at the Café Royal and elsewhere³¹ and ensured their support for Bevan's proposals in the House of Lords from Lord Moran and Lord Dawson.³²

In due course, in 1946 the National Health Service Act contained a provision that the Minister of Health would 'designate as teaching hospitals any hospital or group of hospitals which appears to him to provide any university facilities for undergraduate or post graduate clinical teaching.'³³ Each teaching hospital was to be administered by a Board of Governors responsible to the Ministry of Health and not to the Regional Board in its area. One-fifth of the membership of the Board of Governors could be nominated by the Regional Board but the teaching hospitals were otherwise to lie outside the administrative and financial structure of the hospital service which served in the Regions in which they were situated. Local hospitals were therefore deprived of free access to the best specialist expertise and equipment in their areas. Since teaching and research were virtually confined to designated teaching hospitals, medical students in England and Wales students were deprived of proper experience in the care of the disabled and the chronic sick. In the provinces of England and Wales the teaching hospitals of ten university towns and cities³⁴ were set apart from the Regional hospital system.

the London teaching hospitals, their Boards of Governors and an overly amount of money.' Sir Norman Graham, Assistant Secretary, Department of Health for Scotland, 1945-56. Recorded interview.

³⁰ Pater, *op. cit.*, p. 107.

³¹ *Ibid.*

³² *Ibid.*, p. 124.

³³ National Health Service Act, Part II, 11 (8).

³⁴ Birmingham, Bristol, Cambridge, Cardiff, Liverpool, Leeds, Manchester, Newcastle (Durham), Oxford, Sheffield.

In London this separate designation was even more divisive and had an effect on the functioning of the NHS in every part of England and Wales. Eleven undergraduate teaching hospitals³⁵ and sixteen postgraduate teaching hospitals³⁶ in London were each to be administered by a separate Board of Governors answerable directly to the Ministry of Health. This not only continued the dissociation of London teaching hospitals from other local hospitals but, by allowing the great majority of the undergraduate and postgraduate teaching and research to remain concentrated in London, it confirmed London as the single commanding centre of specialist practice and research in the whole of England and Wales. The London teaching hospitals were also allowed to retain endowments that were, in general, vastly greater than those of provincial hospitals. With greater financial resources, a reputation as leaders in maintaining high standards of practice and a considerable measure of administrative independence, London teaching hospitals perpetuated a culture in London from which Regional hospitals were entirely excluded and with which even the teaching hospitals in the provinces could have only an ambivalent relationship.

It was predominately through this closed culture that the views of the medical profession in England and Wales were presented to government. It was by their contacts with this culture in London that Ministry of Health officials, politicians and many other influential observers judged (often very inaccurately) the attitudes and performance of the medical profession. Great, and arguably undue, influence over the activities and policies of the NHS became vested in bodies outside the structure of the service and not exclusively devoted to its interests. Paradoxically, it was not the full-

³⁵ Charing Cross, Guy's, King's, London, Middlesex, Royal Free, St Bartholomew's, St George's, St Mary's, St Thomas's, University College.

³⁶ Hammersmith Hospital; City of London Maternity Hospital; Hospital for Sick Children; London Chest Hospital; Metropolitan Ear, Nose and Throat Hospital; Moorfields Eye Hospital; National Hospital for Diseases of the Heart; National Hospital for the Paralysed; Queen Charlotte's Hospital; Royal Eye Hospital, Royal National Orthopaedic Hospital, Royal National Throat, Nose and Ear Hospital; St John's Hospital for Diseases of the Skin, St Paul's Hospital for Urological and Skin Diseases, St Peter's Hospital for Skin and Urological Diseases; West End Hospital for Nervous Diseases.

time academic staff, but the Harley Street consultants holding part time appointments at the twenty-seven teaching hospitals in London, that dominated their Boards of Governors and through them could bring influence to bear on Government.

The influence of outside interests on the conduct of the NHS was further reinforced by the composition of the Central Health Services Council, the influential body that not only advised government directly but also determined the composition of all other advisory bodies within the NHS in England and Wales. The National Health Act provided that of the 41 members of the Council 'six shall be the persons for the time holding the offices of President of the Royal College of Physicians of London, the President of the Royal College of Surgeon of England, the President of the Royal College of Obstetricians, the Chairman of the Council of the British Medical Association, the President of the General Medical Council and the Chairman of the Council of the Society of Medical Officers of Health.'³⁷ These ex-officio members, each the formal spokesman of an outside body, made up a large and most powerful group within this very influential body.³⁸ Consultant practice outside the teaching hospitals, general practice, local authority medicine, industrial medicine and the universities together were represented by only thirteen members. This was a continuation of the practice followed in England in appointing the Consultative Council on Medical and Allied Services from 1929 which allowed the management of state health services in England and Wales to be strongly influenced by medical pressure groups from outside the service structure.³⁹

At the Cabinet meeting on 5 October 1945, George Buchanan, the Under-Secretary of State for Scotland, successfully argued against giving teaching hospitals special status and administration in Scotland. He was armed with a short memorandum to this effect, prepared at the Department of Health for Scotland by Sir

³⁷ National Health Services Act, First Schedule.

³⁸ A further two members represented the mental health services.

³⁹ The resulting conflicts have been described by Eckstein in *Pressure Group Politics*, op. cit.

Norman Graham and Sir Douglas Haddow, which was accepted without opposition.⁴⁰

It inevitably followed that the Scottish Health Services Council set up by the Scottish Act was quite different from the Central Council, the equivalent body in England and Wales. Its membership of thirty five was made up of eighteen medical practitioners (unspecified), three dental practitioners, two nurses, a midwife, two pharmacists, four non-medical members, two with experience of hospital management and two with experience of local government. No professional or other body outside the structure of the National Health Service was formally represented on the Council. The chief advisory body in Scotland did not have members necessarily constrained in their commitment to the NHS by a conflicting responsibility to an outside body. The habit of co-operation established by the Scottish Health Board, and encouraged by Cathcart, was continued within the advisory structure of the NHS in Scotland.

The Cathcart Committee's guidance on the organisation of general practitioner services was also followed in Scotland. The family doctor was to be 'the indispensable instrument of national health policy.'⁴¹ Care was taken to ensure that local authorities did not extend their services in any way that might threaten the independent general practitioner. Experience in other branches of public administration indicated that a general practitioner service provided by local authorities would be 'unreliable and would operate unevenly.'⁴² The Cathcart Committee was also well aware that doctors would resist any form or degree of subjection to the local authorities. The Scottish Act was therefore designed to keep the responsibilities of the local authorities within limits that would be generally acceptable. In Scotland, as in England and Wales, the contract of employment of general practitioners was to be with central government for part-time services and remunerated by capitation fees. The general practitioner service was to be

⁴⁰ 'It was very short and it went through, much to our surprise. When he got back, George said that Attlee had congratulated him on this very short and encouraging paper. There was never any argument about it and we went ahead on that basis.' Sir Norman Graham, recorded interview.

⁴¹ Cathcart Report, p. 156.

⁴² Ibid., p. 162.

administered by Executive Councils for areas of convenient size and population and not designed to be coterminous with local authority districts. Cathcart also stressed that general practitioners must act in liaison with the statutory health services.⁴³ In accordance with that recommendation, the White Paper had indicated that health centres would be more extensively provided in Scotland than elsewhere. In Scotland Health Centres were to be provided by the Secretary of State primarily as premises for general practice but also to act as the points of contact and integration of all other services – consultant and specialist services, dentistry, pharmacy, and ‘any of the health services which local or education authorities are required or empowered to provide.’⁴⁴

While the terms of employment of general practitioners in England and Wales matched almost exactly those in Scotland⁴⁵ the organisation of Health Centres was to be critically different. In England and Wales, Health Centres were to be established, equipped and maintained by the local authorities, an arrangement that promised to perpetuate the inequalities and unevenness that Cathcart had found to characterise all local authority services. That they were to be managed and staffed (other than medical and dental staff) by the local authorities (which were no more popular with doctors in England than in Scotland) promised to be a cause of conflict.

Other differences in the NHS Acts for Scotland and England were minor. In Scotland services were organised in areas determined by functional considerations and designed to promote co-operation. Hospital services were organised in Regions large enough to support the full range of hospital services - including medical training, research and development. Those support services essential to hospital practice – ambulances, blood transfusion, bacteriology - were also organised by Regions. General practice and pharmacy, which could provide the full range of their

⁴³ Ibid., p. 169.

⁴⁴ *A National Health Service*, 1944, Cmd. 6502, p. 45.

⁴⁵ In recognition of the differences in dispensing in the two countries, the Apothecaries Act of 1815, which applied only in England and Wales, was not repealed

services within a smaller area, were most conveniently organised into Executive Council districts. Local authority medical services continued to operate in districts coterminous with districts served by other local authority services such as education and public health.

Like the Scottish Act, the Act for England and Wales derived ultimately from the same Cathcart Report. The documents are almost identical in format and, paragraph by paragraph, use the same form of words. The few but significant differences in the Act for England and Wales all serve the same purpose. They incorporate into the Act concessions to special interests – the Royal Colleges, the BMA and other medical institutions, to Harley Street and private practice, to London County Council and the more influential local authorities. These concessions in the Act indicate the existence of conflicts that had not been resolved in the time available before 1946. In his urgent ambition to launch a National Health Services during his term of office in the first post-war Labour Government, Aneurin Bevan had contrived an arrangement which allowed his scheme to be put into operation but which left conflicts of interests unresolved.

For patients with experience of the NHS in Scotland and in England and Wales the differences in service and in care have never been conspicuous. But for those within the Service the differences have from the beginning been unmistakable and all resulted from the divisions that had been allowed to persist within the NHS in England and Wales, with each interest group carefully guarding its place and privileges. Each staff member remained conscious of belonging to a section within the service and on which power group he depended. Within the service in England and Wales there was no easy consensus.

The National Health Service both in Scotland and in England and Wales derived from the Cathcart Report. But in Scotland, in 1936, the Report was an expression of a consensus that already existed. There was no sudden need, as there was in England and Wales, to patch together an agreement under pressure and over a very few short years.

The Cathcart Report and the established consensus were of three-fold importance to the creation of the NHS in Scotland. Had there been no clearly expressed and strongly supported consensus the Secretary of State for Scotland would have had no substantial case in arguing for separate legislation for Scotland. Without separate legislation medical practice in Scotland would have been submerged in the traditional forms, divisions and medical politics of England. Without the strength of the consensus and the agreed policy set out in the Cathcart Report, the NHS could not have been launched and survived successfully in the face of the appalling social conditions and ill health in Scotland that had been so badly underestimated in the Cathcart Report itself.

The civil servants responsible for drawing up the National Health (Scotland) Act were already fully committed to the principles and aims of the Cathcart Report. For them the Report was the essential guide for efficient administration and sound governance.

Some years after his retirement, Ronald Fraser (Assistant Private Secretary to the Secretary of State for Scotland, 1944-47; Cabinet Office 1947-54) remembered:

The Cathcart Report came out in 1936. It was the first study of its kind and had the greatest input into the planning of the National Health Service. It was the fount of all knowledge. Considered in a Scottish context, I have always felt that there was certain artificiality in the later arguments that developed between the government, the BMA and the consultants and specialists and so on. The emergence of the National Health Service was quite inevitable and that really on two levels, first on the political level and second on a purely practical level. It was pretty well inescapable given the political situation at the time. It was also inescapable when you think of the state of the game in general practice...The voluntary hospitals were reduced in the pre-war depression and in the war they were on their beam end, baled out by money put in by the government. If Nye Bevan had not existed we, in Scotland, would have found ourselves carried into a National Health Service just as we were in 1948.⁴⁶

⁴⁶ Recorded interview, 1997.

Sir Norman Graham (Principal Private Secretary to the Secretary of State for Scotland, 1944-45; Assistant Secretary, Department of Health for Scotland, 1945-1946) has similar recollections:

The foundation of the whole National Health Service was undoubtedly the Cathcart Report. In the years after that, especially during the war, the people in the Department got to know the medical profession in a way they never had before. That is, the clinical staff of the voluntary hospitals. It became very clear that something had to be done quickly. When I took over the Hospitals Division of the Department there were different categories of hospital and about thirty different categories of patient. As a brash young man, I thought this was ridiculous. There were people in the Department already working on Cathcart's scheme and one or two were working on the possibility of nationalisation. When Nye Bevan produced his Cabinet paper on nationalisation, I was all for it. If you don't have statutory authority and financial control, to try to get all these hospitals into a pattern and integrated is just not on. There were a lot of the people at the head of the medical profession in Scotland who had been in the forces and had been in a relatively integrated service and were strongly in favour. It also helped that Andrew Davidson was the Chief Medical Officer. Everybody liked him and he commanded the confidence of the medical profession because of what he had done during the war. The leading people in the profession like Joe Wright, Stanley Davidson and Ian Simpson-Hall were all in favour. And about me, no one thought 'Here is a civil servant trying to boss the whole world.' There was no question of antagonism.... Compared with our opposite numbers in the Ministry of Health ours was relatively a downhill run.⁴⁷

Dale Falconer, formerly Scottish Secretary of the BMA, confirmed the lack of conflict in Scotland over the introduction of the NHS:

When the health service came in 1948 the BMA in Scotland played no part at all. The consultants and hospital people were not members. On the other hand the GPs were all members. But they were all very poor and they saw that they were going to be looked after by the National Health Service. So there was no need for the BMA.

⁴⁷ Recorded interview, 1997.

It is now impossible to find any evidence of significant or substantial resistance to the introduction of the NHS in Scotland. It is even more difficult to find any evidence that doctor and nurses in Scotland were influenced by motives that were ideological, doctrinaire or even political. Both doctors and nurses were attracted to a new National Health Service because of its obvious benefits to themselves and their patients. Precise motives varied depending on the circumstances of the individual.

Ekke von Kuenssberg, a GP in the industrial area of Granton from the early 1930s, saw that the NHS was already 'on the horizon in 1936 when the Cathcart Report was published.'⁴⁸ It was his impossible workload at that time that 'made it quite clear to me that if this continues something like an earthquake would happen, and that was of course the Beveridge Report.' It appeared to Dr. Kuenssberg that while all the general practitioners of his acquaintance welcomed these early moves towards the creation of a NHS, the leadership of the BMA was 'a self perpetuating group with a perpetual chairman' apparently out of sympathy with the plans for the NHS. Dr. Kuenssberg became a prime mover in creating a Royal College of General Practitioners and became its first president.

Alex Macewan was a general practitioner in a busy practice in Dunfermline with various additional official appointments including an appointment to the local voluntary hospital. He was a member of the BMA but he 'couldn't get to meetings so never got involved.'⁴⁹ In retrospect Dr. Macewan believed that it was not general practitioners but their wives, the essential but unpaid partners in most practices, who were most urgently attracted by the less harassed life style offered by the NHS.⁵⁰

Dr. J.C. Mercer was a general practitioner in country practice centred on North Berwick. With a substantial private practice he did not find his personal situation much changed but was glad to be relieved of some anxieties in treating his less well off patients. 'I remember a young family I was looking after. Father was working and

⁴⁸ Recorded interview, 1997.

⁴⁹ Recorded interview, 1997.

⁵⁰ This was the view of an elderly GP who had for many years been senior partner in a large practice that had never included a female partner.

was insured. But it was his child who was ill. The question was that if I gave an antibiotic they will have to pay for it. So will I give it now or wait another day to see what happens? Come July 1948 I did not have to worry about the expense of medicine for the children.⁵¹

For many young doctors the NHS opened up opportunities in specialist practice that would have been impossible when hospital employment, especially in the best voluntary hospitals, was unpaid. Some were able to leave assistantships in general practice for new salaried junior posts in hospital; James Williamson, later Professor of Geriatric Medicine at Edinburgh, had two years as an assistant in general practice in England – ‘a miserable time. Medieval medicine in the middle of the twentieth century’⁵² – before finding a training post in hospital medicine in the new NHS. Others like Lord Kilpatrick, a Fife miner’s son, welcomed the coming NHS while they were students and on qualifying were able to make a start to an academic career in medicine that would have been financially impossible before 1948.⁵³

Joyce Granger held a wartime appointment in the Emergency Hospital Service at Bangour. As the war came toward an end ‘there was a feeling of fear about unemployment. I was asked by the [Royal] College [of Physicians] to be part of a sub-committee on the position of women. I was single and had no family commitments but I remember saying that it would be difficult for women, and especially difficult for women with families to consider. But with the NHS it wasn’t an obvious problem.’⁵⁴

Local authority doctors also welcomed the NHS. Before 1948, Christopher Clayson, a consultant in the tuberculosis service, was responsible for the treatment of patients from four local authority areas. ‘The number of beds in my sanatorium had to be divided between four local authorities and had to be allocated in proportion to the amount of money the local authorities were willing to subscribe. Some authorities

⁵¹ Recorded interview 1997.

⁵² Recorded interview 1997.

⁵³ Recorded interview 1997.

⁵⁴ Recorded Interview 1997.

were more worried about their rates and more parsimonious than others. The allocation had to be kept to. All that came to an end in 1948. The entire number of beds came under my complete control and could be used as I thought best.⁵⁵

Miss Orr, a senior ward sister at the Western General Hospital in Edinburgh was delighted to find that in the NHS her salary increased significantly while the job that she enjoyed continued almost unchanged.

Those who welcomed the National Health Service in Scotland did so for an almost infinite variety of reasons and with a wide range of personal motives. But all those motives were contained and supported by the consensus that been established in Scotland over many years. The Cathcart Report was an expression of that consensus and the plan for the future of the health services was followed in Scotland. It also provided much of the structure for the NHS in England and Wales but there the lack of a true consensus left the NHS divided by institutionalised conflicts of interest. In Scotland the consensus was maintained and the shared enthusiasm enabled the new National Health Service in Scotland to contend successfully with a burden of disease so much heavier than that predicted in the Cathcart Report. The National Health Service for Scotland was distinct from that for England and Wales. It was the product of Cathcart and Consensus.

⁵⁵ Ibid.

EPILOGUE

In Scotland, the National Health Service was not a post-war invention but ‘an evolution of services that had been built up over the years by a variety of authorities, voluntary and public’.¹ The reorganisation of Scotland’s health services had been in progress since the publication of the Cathcart Report in 1936. Within two years, Scotland’s hospitals were again being surveyed, now in preparation for war. In 1939, the Emergency Medical Service (EMS) Scheme was set up under the Civil Defence Act and in a very short time Scotland’s total hospital accommodation had been greatly expanded and space had been created for the introduction of new specialist services.² All hospital services in Scotland were now directed and largely financed by the state. The country’s general practitioners had also come under the direction of the state in 1939 through the agency of the BMA’s Scottish Emergency Committee which had been given authority to allocate doctors either to the armed services or to civilian work. By 1948, the medical profession in Scotland already had years of experience of employment or direction by the state and a group of senior civil servants in the Department of Health for Scotland (DoH) had been preparing for further expansion of state control and the establishment of a comprehensive national health service for over a decade.³

¹ *Annual Report of the Department of Health for Scotland*, 1948, Cmd. 7659, p. 11.

² Sir John Brotherston, *The Development of Public Medical Care 1900-1948*, in G. MacLachlan (ed.), *Improving the Common Weal* (Edinburgh, 1987), p. 84.

³ R. P. Fraser, and Sir Norman Graham, recorded interviews. Extended extracts from these and other interviews with civil servants and medical staff in post in 1948 are included in an MSc thesis submitted in 1996.

In his history of the Scottish Office, J. S. Gibson has described these years as 'years of continuity'.⁴ However, they were years of continuing change. James Ford,⁵ on his return to the Scottish Office after service in the Royal Scots and years as a prisoner of the Japanese in Hong Kong, found that the Scottish Office had changed quite remarkably since he had known it between the wars. 'There had been no sweeping changes, not of the kind Margaret Thatcher might have engineered, but the leopard had been required to change its spots.' Before the war, the Scottish Office had been almost entirely a regulatory body 'checking the regulations for importing chrysanthemums and so on.' Senior civil servants 'might advise ministers on the things that should be done but never attempted to achieve much on their own account. Then in the 1940s, 'a new breed of civil servants began to manage and take initiatives'.⁶

Sir Godfrey Collins' early drive to recruit more able and ambitious civil servants to the Scottish Office⁷ had been continued by two of his successors as Secretary of State, Walter Elliot and Tom Johnston. The Department of Health had come under the influence of the 'Young Turks'⁸ who were 'driving change and were hard drivers'.⁹ Although not in the most senior posts at that time, they took the initiatives and set the pace. Ronald Fraser brought useful experience from his years in the Cabinet Office and R. C. Johnson, although not yet the Secretary of the Department, was virtually 'in charge'.¹⁰ Douglas Hadow toured the United States to

⁴ J. S. Gibson, *The Thistle and the Rose* (Edinburgh, 1985), p. 112.

⁵ J. Ford, recorded interview. James Ford was a senior civil servant in the Scottish Office and also a novelist.

⁶ Ibid.

⁷ See above, Ch. 2, p. 64.

⁸ Later Sir R. C. Johnson, Ronald Fraser CB, Sir Norman Graham, Sir Douglas Hadow and James Hogarth CB.

⁹ A. L. Rennie CB, recorded interview.

¹⁰ Ibid.

study the administration of what were then generally recognised as the world's most modern hospital services.¹¹ In 1951, Norman Graham travelled to Switzerland to negotiate a contract for the treatment of Scottish tuberculosis patients in the sanatoria that had lain almost empty since the outbreak of war. (Patients from England and Wales were later included in the scheme.) James Hogarth successfully conducted all negotiations with the medical profession; meetings were arranged and chaired by Sir Andrew Davidson who, as Chief Medical Officer in Scotland, had established good working arrangements between the state and the country's doctors during the war and had become respected and trusted by the medical profession.

There was no entrenched opposition to the NHS in Scotland and Sir Norman Graham remembers that attitudes at meetings between doctors and civil servants were invariably positive. The senior civil servants leading the Department of Health at that time describe themselves as being well organised in promoting a national health service - 'there was an extremely determined Scottish dimension to that organisation',¹² - and determined, in the years of planning the NHS and in the years of its consolidation, not to accept dictation by the Ministry of Health but to take their own initiatives in shaping services for Scotland.¹³

The Scottish Office saw itself very much in the traditional civil service mode of serving ministers of all parties with equal zeal. But it also saw itself as the advocate of Scotland. This was the case in relation to the NHS just as in the case of regional development. The question of getting major income and investment for Scotland involved a degree of competition with the North of England and with Wales. The Scottish

¹¹ Sir Douglas Hadow's diary of this tour was kindly lent by his son.

¹² Ibid.

¹³ 'When money was made available for Civil Defence on the outbreak of the Korean War the Ministry of Health spread its share around in penny packets here and there. But since the Clyde was the most likely target area for a nuclear attack we decided to build a new hospital at Vale of Leven and to build it to a higher standard than other hospitals. We meant it to be an experience for every body of what a hospital should be.' Sir Norman Graham, recorded interview.

Office had a strong ethic that our purpose was to deliver the best public service in Scotland that we could.¹⁴

The NHS for Scotland had come after years of preparation. There had been no entrenched opposition to overcome and the service had been planned, introduced intact and consolidated in a spirit of co-operation and there had been no last minute deviations from the concept of a tripartite organisation. From the start, the NHS was welcomed in Scotland, by the public,¹⁵ the civil service and the medical profession. Even Scotland's leading conservative newspaper, the *Scotsman*, supported the creation of this new state service. The *Scotsman* was also confident that the NHS would work better in Scotland than in England.¹⁶ From the beginning, the NHS in Scotland was accepted as a welcome and permanent addition to the social structure of the country.

The NHS for England and Wales had a less whole hearted welcome and it soon came to suffer uncertainties and disagreements, the consequences of the 'precipitous and haphazard manner'¹⁷ in which it had been put together. Visiting England in 1949, the Professor of Medicine at Harvard, J. H. Means, saw the NHS as a creation of a country in 'an extremity' at the end of the Second World War and with

... no economic recourse but to establish some sort of national health programme. No way of supporting the nation's hospital structure, or of assuring medical care to all the King's subjects, was available except through government. The health bill had to be budgeted along with the cost of defence, welfare, food, transport and housing. The country had to decide what it could afford to spend on health and plan accordingly. Such planning obviously could only be done by government.¹⁸

¹⁴ Rennie, op. cit.

¹⁵ *Glasgow Herald*, 5 July 1948.

¹⁶ Brotherston, op.cit., p. 93.

¹⁷ C. Webster, *The Health Services Since the War*, ii (London, 1996), p. 27.

¹⁸ J. H. Means, 'Medicine and the State', *Edinburgh Medical Journal*, 1953, clxx, p. 56.

At that first visit he found the medical profession in England so discontented that he was uncertain if the NHS would survive. It was not until three years later that the doctors in the NHS in England seemed 'by and large more reconciled to it' and the people 'satisfied, sometimes enthusiastic about it'. Only now was he convinced that in England the 'National Health Service is here to stay and in all probability it will gradually be improved'.¹⁹ The official historian has also written that it was not until the mid-fifties that the NHS had the support of 'a broad consensus, embracing all social classes, both political parties and all but an eccentric fringe of the medical profession'.²⁰

However, in the 1950s the NHS in Britain still had many difficulties to overcome and the hoped for improvements soon become almost impossible. The structure of the NHS had been negotiated in England in a climate of 'acrimonious controversy'.²¹ Agreement had only been achieved after concessions had been made to the teaching hospitals in Paragraph 15 of the National Health Service Act (1946) and to the local authorities in Paragraph 40. These concessions had created fault lines in the tripartite organisation of the service, fault lines that were revealed when, within months of its introduction, the new NHS was confronted by unforeseen difficulties.

A crucial problem was finance. The Treasury and the Ministry of Health had underestimated the financial demands of the new service. In the first nine months the Estimated Gross Expenditure had already been exceeded by 39%.²² In November 1949, Bevan complained of 'the cascade of medicine which is pouring down British throats at this time'.²³ Expenditure on medicines continued to increase and in 1953,

¹⁹ Means, op. cit., p. 60.

²⁰ C. Webster, *The Health Services Since the War*, i (London, 1988), p. 389.

²¹ Ibid.

²² Webster, 1988, op. cit., p. 134.

²³ A. Bevan, quoted by J. Campbell, *Nye Bevan; A Biography* (London, 1987), p.183.

Iain Macleod, now the Minister of Health, reported that the drugs bill, which had risen to over £46,000,000, was prejudicing even the most urgent developments.²⁴

By far the greatest demand for medicines was in general practice and the demands on general practice had increased enormously even within the first months of the NHS both in England and Wales and in Scotland. In Scotland, where only a very small number of doctors had continued in private practice, there were 2,364 doctors on the lists of the Executive Councils in the first years of the service.²⁵ The average numbers of patients on a general practitioner's list was therefore only a little over 2,000, not a large list even by present day standards. But suddenly after July 1948 consulting hours had to be extended, waiting rooms were uncomfortably full and, in some cases, there were queues outside doctors' surgeries.²⁶ It was not only that both the doctors' services and the medicines were free that attracted patients. The new medicines – notably penicillin, streptomycin and cortisone – were infinitely more effective than anything that had been available before.

Unable to interfere directly with the doctors' right to prescribe freely for their patients because of the provisions of the contract negotiated with the general practitioners, the government quickly attempted to reduce costs by imposing prescription charges in the National Health Service (Amendment) Act at the end of 1949. The charge of one shilling for each prescription had virtually no effect on the level of demand, either in Scotland or in England and Wales and a Joint Committee of the English and Scottish Health Service Councils was appointed to advise on prescription practices in both countries.²⁷ It was hoped that general practitioners could be persuaded to prescribe only the cheapest brands of the new drugs. In the Budget in

²⁴ *Lancet*, ii, 1953, p. 828.

²⁵ *Annual Report of the Department of Health for Scotland*, 1948, Cmd. 7659, p. 13.

²⁶ *Ibid.*

1951 further attempts at economy were made by imposing charges on spectacles and false teeth. The annual number of applications for dentures in Scotland immediately dropped from 284,000 to 150,000.²⁸ The effect on the prescription of glasses was much less; patients continued to use the free eye-testing services but used the results to have spectacles prescribed privately.²⁹ The responses to the imposed economies in general practice were similar both north and south of the border and, although the new charges caused complaints and criticism, in neither country did they threaten the operation of the NHS.

That was not the case when efforts were made to achieve economies in the hospital service. The hospital service was the largest element within the NHS and the section over which central government had most direct control.³⁰ It was therefore the hospital service that came under the most critical review in the effort to contain costs³¹ and the chosen target was the growing cost of its staff. The Secretary of State for Scotland, Arthur Woodburn, who had resisted the introduction of charges on prescriptions,³² was quite prepared to accept the government proposals to contain expenditure in the hospital service.³³ Sir Norman Graham, who was then in charge of the Hospital Division of the Department of Health for Scotland, remembers that on this issue he felt at an advantage over his opposite number in the Ministry of Health.³⁴ In 1948, Scotland already had a hospital bed complement 15% greater per head of population than England and Wales and his Division had been quicker to increase capital investment. Since it was Treasury policy that revenue moneys should follow

²⁷ *Annual Reports of the Department of Health for Scotland.*

²⁸ *Annual Report of the Department of Health for Scotland, 1952, Cmd.8799, p.21.*

²⁹ *Ibid.*

³⁰ Webster, 1988, op. cit., p. 298.

³¹ *Ibid.*

³² *Ibid.*, p. 147.

³³ *Ibid.*, p. 148.

capital investment, Scotland was relatively well placed financially.³⁵ By 1948 Scotland also had proportionally 30% more nurses and 45% more hospital medical and dental staff manning only 15% more beds and was therefore in a better position to withstand any limitation of recruitment that the government might impose.³⁶

In England and Wales there was active and effective resistance to the Treasury's proposed restrictions on hospitals. At the Treasury's first call for control of recruitment of hospital staff in 1949, Bevan insisted that the prescription of staffing levels by the Ministry of Health would be inconsistent with the Ministry's established policy of local autonomy.³⁷ The Treasury pointed out that, in Scotland, staffing levels were controlled centrally and recommended that the same practice should be followed by the Ministry of Health in England and Wales. The Ministry was not only reluctant to adopt the Scottish practice, it also had to confess that it neither held the relevant statistics nor the results of any reviews of staffing levels that might already have been carried out. Under additional pressure from the Public Accounts Committee and the Select Committee on Estimates, the Ministry was persuaded to set up a complex enquiry into establishment levels in each separate section of the hospital service. Boards of Governors and management committees in England and Wales created difficulties and the Treasury very quickly decided that this enquiry was 'a farce set up to appease the Public Accounts Committee but without any real prospect of its recommendations becoming effective.'³⁸ The medical elite in England and Wales - the 'voice at court' discussed in this thesis³⁹ - operating directly at a personal level and also through the Boards of Governors and medical committees which they

³⁴ Sir Norman Graham, recorded interview.

³⁵ Ibid.

³⁶ Graham, *op. cit.* and Webster, 1996, *op. cit.*, Appendix 3.25 and Appendix 3.29.

³⁷ Webster, 1988, p. 299.

³⁸ Ibid., p. 301.

dominated, had shown their ability to influence or even obstruct recommendations of government.⁴⁰ This episode also illustrates the lingering opposition within the Ministry of Health to any increase in central administration, which, as one of its senior officers, John Pater, has made clear, was the traditional stance of the Ministry of Health.⁴¹

In October 1951, a Conservative government came into office. The new Chancellor now insisted that the Treasury's recommendations for restrictions on spending on hospital staff must be carried out. From its position of strength 'the Scottish Department of Health acceded readily'.⁴² In England and Wales, the Ministry of Health, now under a new Minister, was persuaded to relax its opposition to any increase in central administration and began to force the restrictions required by the Treasury. The consultants and administrators of the London teaching hospitals, now acting in their own interest and not on behalf of the hospital service as a whole, made public their resentment at what they regarded as Ministerial interference with the privileged position that they had been given in the National Health Service Act. Any private assurances that may have been given by Aneurin Bevan over dinner at the Café Royal and elsewhere⁴³ clearly now counted for nothing. In a letter to the *Times*, Mr. A. H. Burfour, a leading London consultant, wrote:

The London Teaching Hospital at which I am now employed has a tradition of independence going back for more than two and a half centuries and is respected world-wide. On the introduction of the National Health Service there were high hopes that that tradition would be respected and its reputation enhanced.⁴⁴

³⁹ See above, Ch. 2, pp. 76, 79.

⁴⁰ Webster, 1988, op.cit., p. 301.

⁴¹ J. Pater, *The Making of the National Health Service* (London, 1981), p. 26.

⁴² Webster, 1988, op. cit., p. 302.

⁴³ Campbell, op. cit., p. 171.

⁴⁴ Leader, 'Frustration in the Hospitals', *BMJ*, ii, 1953, p. 319.

Mr. Burfour complained that even in matters of detail the Board of Governors at his hospital was being obstructed. Not even the engagement of a porter was possible without Ministerial approval. Mr. Rowlandson, a surgeon at another London hospital, and Lord Knollys, an administrator at a third, also wrote to the *Times* complaining about this unexpected loss of independence by their hospitals. Sir Russell Brain protested in a letter to the *BMJ*.⁴⁵

However, the teaching hospitals did not have the sympathy of other sections of the NHS in England and Wales. London's Medical Officer of Health, Sir Allen Daley, devoted his Croonian Lecture to the Royal College of Physicians of London to pointing out that the great London hospitals were not pulling their weight. 'The individual hospitals must remember that they are part of a national hospital service with a collective responsibility for the institutional care of the sick.'⁴⁶ Sir Allen told his audience of London's medical elite that, in spite of the practical difficulties, 'it is not beyond the realm of realism to go back to the Willink proposals'.⁴⁷ This would have effectively put the administration of the NHS under the control of the local authorities to be managed by joint committees of the county councils and county boroughs.⁴⁸ Such restructuring might have found support among the local authorities themselves and possibly some lingering sympathy among the more long serving officers of the Ministry of Health who had originally favoured such a scheme. But the Willink proposals had been vigorously

⁴⁵ Sir Russell Brain, *BMJ*, ii, Supplement, p. 206.

⁴⁶ Sir Allen Daley, 'The Place of the Hospital in a National Health Service', *BMJ*, ii, 1953, p. 249.

⁴⁷ *Ibid.*, p. 243.

⁴⁸ Webster, 1988, op. cit, p. 56.

resisted by the medical profession when they were first put forward in 1944⁴⁹ and as Bevan, as Minister of Health, had informed the Cabinet in 1945, 'Few local authorities run a good hospital system. The majority are not suited to run a hospital service at all.'⁵⁰ In 1953, Sir Allen Daley's proposals came to nothing.

The local authorities later came under criticism in a different context. In 1953, the Minister of Health, now Ian Macleod, made public his dissatisfaction with the local authorities in the exercise of the powers that they had been given in the administration of general practitioner services. He now had it in mind to change the constitution of the Executive Councils as set out in the National Health Service Act of 1946. 'Lay members did not always attend and in that respect the members appointed by the local authorities appear to be by far the worst.'⁵¹ The Minister had been aware that relations between the local authorities and the general practitioners had long been unsatisfactory but he had been somewhat reassured in recent special reports from the local authorities that in 1953 there was 'growing co-operation'.⁵²

The general practitioners did not agree. A survey of general practice found that local authority services and the general practitioners were often in conflict and seemed 'to be treading different paths.... Maximum benefit for the patient cannot result from a bisected service.... The NHS is crying out for a unified administration.'⁵³

⁴⁹ P. Bartrip, *Themselves Writ Large: The British Medical Association 1932-1966* (London, 1996), p. 240

⁵⁰ The Future of the Hospital Services, CP (45) 205, PRO CAB 129/3 quoted by C. Webster, *Aneurin Bevan on the National Health Service* (Oxford, 1991), p. 33.

⁵¹ Survey by the Minister, *Lancet*, ii, 1953, p. 828.

⁵² Ibid.

⁵³ S. J. Hadfield, 'A Field Study of General Practice', *BMJ*, ii, 1953, p. 706.

After five years, the NHS in England and Wales was far from united. There were tensions between the different sections – general practice, local authorities, the hospital service, the teaching hospitals and the Ministry itself. The disagreements were not so severe as to threaten the continuing existence of the service but the staff of each section of the service tended to identify with that particular section rather than with the service as a whole. There was a degree of co-operation but it was not habitual or always readily given. The habit of co-operation that had grown up in Scotland over almost half a century was missing in England and Wales. It had not developed by 1946 and the National Health Service Act, by allowing concessions to the teaching hospitals the local authorities, had perpetuated in England a source of continuing conflicts of interest that did not exist in Scotland.

Nevertheless, the National Health Service came to be well regarded by the public in both England and Wales and in Scotland. But after ten years of introduction, consolidation and operation and an unexpectedly high financial outlay, it had become clear that the National Health Service, of itself, was not destined to improve the health of the population as measured by the conventional measurements. In 1948, the neonatal death rate, the infant mortality rate, the maternity mortality rate and the overall death rate in Scotland were already at the lowest levels on record.⁵⁴ The Department of Health for Scotland reported that in the ten years before the introduction of the NHS, ‘despite the fact that five of them were years of war’, improvement ‘has exceeded the most optimistic expectations’.⁵⁵ As measured by such statistics, the introduction of the NHS had had little effect by 1958. In the course of its first ten years, Scotland’s standardised death rate had fallen by only 13.5%

⁵⁴ *Annual Report of the Department of Health for Scotland, 1948, Cmd.7659, p. 9.*

compared with 21% in the previous decade. The Department of Health for Scotland attributed this continuing improvement to better nutrition, better housing and 'social amelioration generally'.⁵⁶ Since the introduction of the NHS the maternal mortality rate had fallen by 42% compared with a remarkable 68% between 1938 and 1948; this was attributed in part to the control of puerperal sepsis by new antibacterial drugs, but principally to improved nutrition during pregnancy and the elimination of rickets which had previously been a common cause of pelvic deformity and difficult birth. Infant mortality had also improved both before and after 1948. The Department of Health believed that 'infant and maternal death rates are sensitive indices of the presence or absence of malnutrition in the community and the favourable progress of the past few years can be regarded in that light'.⁵⁷

The NHS could claim little credit when, in 1952, the DoH gave first place in its annual report to the successful containment of the infectious diseases of childhood. Scarlet fever as a cause of death has 'been virtually eliminated'⁵⁸ by effective antibacterial treatment for streptococcal infections. The annual number of deaths in Scotland from diphtheria had fallen to eight compared with 290 only ten years before, the result of a campaign to increase public acceptance of immunisation launched by the DoH early in 1946. That the two-yearly fluctuations of whooping cough and measles had ceased by 1952 and the severity of the illnesses had declined was thought to be due to better nutrition and the consequent improvement in resistance of the country's children.

The most outstanding improvement in the years after 1948 was in deaths from tuberculosis, the commonest cause of death of young adults, especially young women.

⁵⁵ *Annual Report of the Department of Health for Scotland*, 1949, Cmd.7921, p. 12.

⁵⁶ *Ibid.*, 15.

⁵⁷ *Ibid.*, 13.

The war years had seen a sharp increase in the number of deaths but with the introduction of streptomycin treatment in 1947 and a campaign of early diagnosis by mass radiography beginning in 1951, the death rate from tuberculosis had fallen by 85% by 1958.

As was evident from these figures, falling death rates did not reflect the changes taking place in the provision of medical services. By 1948, the DoH had already recognised that statistics that had been used successfully in the past to assess the effectiveness of public health measures were not going to be 'helpful as guides to future action' in the National Health Service. This quickly proved to be the case. After five years, mortality rates had continued to improve but on average everyone in Scotland was consulting his doctor five times a year and out of a total population of 5,096,000 no fewer than 2,022,000 had been seen as hospital out patients. The DoH observed that 'demands on the curative services continue at a high level and show no signs of abating. In terms of hospital attendances it might seem that ill health is increasing.'⁵⁹

A comprehensive free service had inevitably become demand led. To satisfy that demand the resources required would be determined by the patients' perception of need and were therefore potentially infinite. This had been the lesson of the twenty-five years of experience of a comprehensive medical service in the Highlands and Islands Medical Service and it came as no surprise to the Department of Health for Scotland in 1948. In England and Wales this lesson had been ignored.

The planners of the Health Service - not merely Bevan but, more extraordinarily, all the officials of the Ministry [of Health] who had been responsible for working out the different administrative models

⁵⁸ *Annual Report of the Department of Health for Scotland*, 1952, Cmd. 8799, p. 14.

⁵⁹ *Annual Report of the Department of Health for Scotland*, 1954, Cmd. 9417, p. 15.

over the past six years - comprehensively underestimated what it was going to cost. They simply projected forward the amounts estimated to have been spent on health care before the war; indeed they actually expected that the cost of the of the Service would grow less as the population got healthier ... they entirely failed to see that, far from declining, the demand for treatment, once free from financial constraint, would prove literally infinite, and the capacity of the medical profession to devise expensive new treatments scarcely less.⁶⁰

It took the Ministry of Health some time after 1948 to see what had been quite apparent in the experience in Scotland from the beginning.

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From the beginning, the National Health Service, as set up by the National Health Service (Scotland) Act of 1947, had significant advantages over the service as set up in England and Wales. Scotland had a devolved health bureaucracy able to respond to the particular needs of a relatively small society. In England and Wales, the Ministry of Health had the task of providing a universal service to a large population made up of disparate communities living in widely different social and economic circumstances. In England and Wales the component parts of the service – general practice, local authorities and voluntary, municipal and teaching hospitals – had comparatively little experience in coming together for a common purpose. Rather than ensuring a unified service, the National Health Service Act of 1946 had perpetuated the separate identity of the teaching hospitals, the centres of excellence on which the whole service depended, and allowed local authorities to continue to administer services often beyond their capabilities. These anomalies were allowed to continue for more than a generation. The concessions allowed in Paragraphs 15 and 46 of the National Health Service Act, 1946 - the only differences between the Act for England

⁶⁰ Campbell, *op. cit.*, p. 180.

and Wales and that for Scotland - were eventually recognised as regrettable and were corrected in 1974. Thereafter, the statutory provisions north and south of the border differed very little but by then the separate parts of the service in England and Wales had been made conscious of their separate identities and interests and the potential for disharmony persisted.

Established in the earliest years of the century, the roots of the National Health Service in Scotland were much deeper than in England and Wales. During the distress and ill health of the 1920s and 1930s the Scottish Board of Health, together with a medical profession with a tradition of public service, established a habit of co-operation and a common sense of purpose. On the Appointed Day, 5 July 1948, the Department of Health for Scotland was able to promise to maintain a 'balance and harmony'⁶¹ that already existed. Even when the differences in the formal organisation of the two services had to a large extent been eliminated, it was this 'harmony' and the continuing habit of co-operation that, for those working in the NHS in Scotland, most clearly distinguished the service in Scotland from that south of the border where entrenched habits of difference linger on.

After fifty years the National Health Service is failing to maintain standards of performance achieved in other countries in Western Europe. A reconstruction of the service seems inevitable. It may be expected that the necessary reforms of the British National Health Service will be carried with relative ease in Scotland where divisions and conflicts of interest have never been so much a part of its history.

⁶¹ *Annual Report of the Department of Health for Scotland*, 1949, Cmd.7921, p. 9.

APPENDIX I

WHO SHOULD SPEAK FOR THE MEDICAL PROFESSION?

Throughout 1912, from its London base, the British Medical Association conducted an aggressive campaign to dictate the terms and conditions under which doctors would take part in the National Health Insurance Scheme. The outcome of the campaign was 'the eventual trouncing of the British Medical Association'¹ and a distortion of the public perception of the medical profession as united in support of the intemperate behaviour of the officers of the BMA, a perception that has been reinforced by frequent repetition. Misconceptions of the authority of the BMA as the single voice of the medical profession persisted, causing misunderstandings during the evolution of the National Health Service. Historians of this period have overestimated the degree to which the officers of the British Medical Association faithfully represented the views of the members and have tended to perpetuate the myth that, in the struggles to launch the NHS, the BMA and the medical profession in Great Britain were synonymous. Eckstein refers to the BMA as the 'nearly monolithic formal organisation'² of the profession. Eder equates the BMA leadership with the medical profession without question and goes so far as to say that 'professional solidarity was unshakeable'³. Pater⁴ refers to the BMA but not to any other section of the profession. Honigsbaum⁵ writes of 'the doctors' and the 'BMA' indiscriminately. For Ross the 'BMA' and the 'medical profession' are interchangeable (even in his index).⁶

¹ V. Berridge, *Health and Medicine* in F. Thompson (ed.), *The Cambridge Social History of Britain, 1750-1950* iii (Cambridge 1990), p. 183.

² H. Eckstein, *Pressure Group Politics; The Case of the British Medical Association*, (London, 1960), p. 49.

³ N. Eder, *National Health Insurance and the Medical Profession* (London, 1982).

⁴ J. Pater, *The Making of the National Health Service* (London, 1981).

⁵ F. Honigsbaum, *Health, Happiness, and Security* (London, 1989).

⁶ J. Ross, *The National Health Service in Great Britain* (Oxford 1952).

Jones has noticed that the British Medical Association in 1911 and 1912 'recognised a crucial opportunity to achieve its desires for the profession and to enhance its own position'⁷ but makes no reference to the power struggle then taking place within the medical profession and which had reached a climax as Lloyd George negotiated the introduction of his scheme for National Health Insurance.

At the turn of the century, there was no Ministry of Health and government authority over medical matters lay with the Privy Council and the Secretary of its Medical Committee. In turn the Medical Committee of the Privy Council was guided informally by the Royal College of Physicians of London which had 'always been close to the Crown and the establishment'.⁸ It had long been the routine practice of the Privy Council to consult the London College on routine matters. In one typical year (1907), the Privy Council referred to the College requests for advice: from the Secretary of State for India on the control of plague; from the Home Office Committee on Ambulance Services; from the Board of Trade (Marine Department) on the medical inspection of seamen; from the Colonial Secretary on the management of beriberi in St Helena; from the Local Government Board on the management of an outbreak of plague in East Anglia.⁹ The London College had also been acting as advisor to the Army Medical Department since the Crimean War.

Even on matters on which it had not been formally consulted the College often 'decided to use its influence.'¹⁰ Although it spoke as from the medical profession, the College was by no means a representative body. In 1909, when its position was finally challenged, there were 40,257 medical practitioners on the Medical Register; of these a total of 12,524 were Fellows, Members or Licentiates of the Royal College of Physicians of London. However, only the 339 Fellows were entitled to vote at the Ordinary General meetings that were held only four times a year, and at which as few

⁷ P. Jones, *Doctors and the BMA* (Farnborough, 1981), p. 25.

⁸ A. Cooke, *A History of the Royal College of Physicians of London* (Oxford, 1972), p. 1123.

⁹ Minutes of the Royal College of Physicians of London, 1907.

¹⁰ Cooke, *op. cit.*, p. 835.

as 10 fellows constituted a quorum. (In practice, the real business of the College was conducted by a Council of 17 Fellows including the President, the four Censors and the Treasurer.) Nevertheless, as Eckstein has observed, the Fellows of the Royal College of Physicians of London regarded themselves as the high court of British Medicine.¹¹

In 1909, the College faced a challenge to its position from the British Medical Association. In the last days of 1908 the British Medical Association had lodged a petition for the Grant of a Royal Charter of Incorporation 'in order to enable the Association to undertake more completely than hitherto all the proper means for promoting the efficiency and welfare of the medical profession and the advancement of the sciences of medicine and surgery.'¹² This political bid by the BMA was a major departure from the original concept of the Association's founder.

In 1828, Charles Hastings, an Edinburgh graduate, founded a medical journal, the *Midland Medical and Surgical Reporter* as a vehicle by which provincial practitioners could communicate with each other, sharing their experience and making their contribution to the advance of medical science. In 1832 its promoters formalised themselves as the Provincial Medical and Surgical Association (PMSA). Membership was not restricted to medical practitioners but its aims were confined to 'gathering information from medical practice, increasing knowledge of medical topography, investigating disease, and advancing medico-legal science'.¹³ The Association centred on Worcester but wider participation was encouraged by holding the annual meetings in different provincial towns. This was a case of the Mountain going to Mohammed. Few of the foot soldiers of the profession could afford, in time or in money, to travel far from home for 'science, good fellowship and philanthropy'.¹⁴ For each annual meeting a President was selected from the most distinguished of the local practitioners

¹¹ Eckstein, op.cit., p. 50.

¹² *BMJ*, i, 1909, p. 3.

¹³ P. Bartrip, *Themselves Writ Large: The British Medical Association, 1832-1966* (London, 1996), p. 5.

¹⁴ *Ibid*, p. 36.

in the area in which the meeting was to be held; the President held nominal office only for one year and took no part in the conduct of the Association's affairs. In time the PMSA evolved to become the British Medical Association and moved its headquarters from Worcester to London. An attempt to amend the constitution in 1896 failed because of the lack of interest shown by the members¹⁵. The fundamental problem was that the Association had a very high proportion of unattached members (i.e. not affiliated to a Division) whose membership allowed them free subscription to the Association's journal, the *BMJ*, but who had no further interest in the affairs of the Association. In order to encourage greater participation by members, in 1901 the Annual Representative Meeting restructured the Association, creating a constitution later described by Michael Foot as 'a democratic machine seemingly constructed by Dr.Strabismus.'¹⁶ At Annual Representative Meetings, each Division would now be represented by a delegate, able to vote according to the instructions of his Division and exercising a number of votes that reflected the number of members in his Division. Resolutions passed at the Annual Representative Meeting, if secured by the votes of two thirds of those present were to be binding on the council. A quorum was to be half of the number entitled to attend. In order to encourage attendance the Association undertook to pay the delegates' expenses. However ordinary members could not attend Annual Representative Meetings and there was no postal voting system; the new constitution was intended to increase membership, but the Council of the BMA in London was careful to retain its ability to 'tower'¹⁷ over the Annual Representative Meetings. Effective power remained in the hands of 'a small circle of inner council members and permanent officials.'¹⁸ Within this inner circle the most powerful political figure was the Chairman of Council, elected by the council 'for such time as it determines' but in practice...that seems as long as he wants to hold

¹⁵ 'Of the associations 37 United Kingdom branches, only 18 offered views on the proposed reforms. There was only one question to which all 18 replied. Of the proposals tabled, not one received a ringing endorsement'. Bartrip, op.cit., p. 140.

¹⁶ M. Foot, *Aneurin Bevan* (London, 1973), p. 117.

¹⁷ Eckstein, op. cit., p. 60.

¹⁸ Bartrip, op. cit., p. 148.

office.¹⁹ The Chairman of Council and his inner circle were supported by a secretariat of permanent officials, headed by a Secretary with wide powers to supervise the whole organisation. While scientific questions were farmed out to *ad hoc* committees made up from the many experts available within the wide membership, the inner circle retained the monopoly on political issues through appointed medico-political committees of activists. Theoretically, ordinary members could contribute to decision making through their Divisions but as Alfred Cox, a former Secretary of the Association, recalls in his memoirs,²⁰ at the turn of the century meetings were infrequent and it was the medico-political committees, convened in London, that produced the reports which formed the substance of all official statements made by the BMA.

At the turn of the century the BMA carried little weight. In 1897 the *Times* declared:

It would be impossible to point to anything the association has done, either for the benefit of the medical profession or for mankind, at all adequate to the apparent possibilities of the case. Probably no states man was ever influenced by its views with regard to any matter of legislation, whether purely medical or relating to some one of the many social questions upon which medicine is calculated to throw light²¹

In 1904 the Annual Representatives Meeting was held at the height of the agitation over the evils of club and contract practice ('mass medicine'). Medical Unions had been formed in various parts of the country, often in mining areas, to secure reform. The campaign had been taken up by the *Lancet* in a series of articles entitled 'The Battle of the Clubs'. It was Cox, who later became its Secretary, who persuaded the BMA in 1900 to take up the cause.²² But almost nothing was achieved; the ineffectiveness of the BMA's advocacy on behalf of the profession was becoming

¹⁹ Eckstein, op.cit., p. 60.

²⁰ A. Cox, *Among The Doctors* (London, 1950).

²¹ *The Times*, 1 September 1897.

²² Eckstein, op.cit., p. 75.

more and more obvious. Recruitment was failing as a result. In the period 1890-1895 membership had increased by 15%; from 1895 to 1900 the increase was 14%. Now for the years 1900 to 1905 the increase was only 6%²³. In the worst year ever, 1907, only 130 new members were recruited²⁴ while the number in the profession increased by 444²⁵.

To a number of those attending the annual meeting in 1904 it seemed that some attempt should be made to increase the authority of the BMA:

A resolution was passed instructing the Central Council to take steps to effect such changes in the Constitution of the Association as would enable it to carry out its objectives more freely. When this task came to be to be undertaken the Council was advised by the eminent lawyer consulted that the time had come to consider whether application should not be made for a Royal Charter²⁶.

A first draft of the Petition for a Royal Charter was brought before the annual meeting in July 1906 and a revised version in May 1907. The formal application was submitted to the Privy Council by the BMA leadership on 21 December 1908. Over four years, drafts of the proposed Chapter had been debated at successive Representative Meetings²⁷ but support had remained much less than whole hearted.

The Petition stated that 'greater freedom of action is desirable in order to enable the Association to undertake more completely than hitherto all proper means for the promoting of the efficiency and welfare of the medical profession and the advancement of the sciences of medicine and surgery.'²⁸ The full intention is clear from the text of the *Draft Charter, Ordinances and Byelaws* presented to the Annual Representative Meeting in 1908 and from the reports of the debates on the drafts at Representative Meetings. Armed with a Charter, the leaders of the Association could expect to be consulted by government in 'the framing and carrying out of legislation

²³ Calculated from figures supplied by the Archivist of the BMA.

²⁴ *BMJ*, i, 1908, p. 290.

²⁵ Medical Register, 1908.

²⁶ *BMJ*, i, 1908, p. 1267.

²⁷ Reported in full in *BMJ*, Supplements, ii, 1907; i, 1908; and ii, 1908.

²⁸ The text of the Petition is reproduced in *BMJ*, Supplement, i, 1909.

affecting the public health, the Poor Law, the treatment of lunacy and inebriety and other matters as to which the members of the medical profession have special knowledge.'²⁹ The BMA would become a disciplinary body controlling standards of practice and conduct. It would also act for individual members 'against unjust attacks and accusations;' it would 'establish benevolent funds for the benefit of members of the medical profession and their families.' Most contentious of all, the ultimate responsibility for the exercise of these wide-ranging powers would be vested in the Representative Meetings.

The petition was submitted to the Privy Council. In accordance with its long-standing practice, the Privy Council consulted the Royal College of Physicians of London. Since a Charter in the terms set out by the BMA would inevitably undermine the position of the Royal College of Physicians, the College at once sought legal advice. Counsel's opinion (Sir Alfred Cripps) reads:

The Charter would in effect constitute a body of co-ordinate and parallel jurisdiction.

The object of the Association to take any legal proceedings, civil or criminal, on which the honour or interests of the medical profession or any member of the Association in his professional capacity is or are involved, is one which should be opposed. It would constitute the Association a public prosecutor and the power might be exercised against medical men who were not desirous to join the Association.³⁰

The College advised the Privy Council that the application for a Royal Charter should be refused.

The Royal College of Physicians of London was not alone in its opposition. Counter petitions were submitted to the Privy Council by the Royal College of Physicians of Edinburgh, The Royal College of Surgeons of Edinburgh, Edinburgh University, the British Medical Benevolent Fund, and the Society for the Relief of

²⁹ Ibid., p. 3.

³⁰ *Annals of the Royal College of Physicians of London*, lxxv, 26 January 1909.

Widows and Orphans of Medical Men. Counter petitions were also lodged by a number of branches of the BMA itself (including the Edinburgh Branch) and by individual members of the Association³¹. Members of the medical profession, not members of the BMA, wrote in protest to the *BMJ*.

The objections were on two main grounds. There were many, especially in Scotland, who believed that the BMA should not follow this path at all. There would be a conflict of interests with the General Medical Council and ‘...political proposals would be impracticable and would raise internal dissension in the Association. It was very much better that the Association should take no part whatever in political matters.’³² There was even more objection that the structure and procedures of the BMA made it unsuitable for the exercise of such power. In particular, it was felt that the ultimate authority should not be vested in the Annual Representative Meeting that could not pretend to be a democratic body. One general practitioner wrote to the *BMJ*:

No one desires to see a large majority of the Association disenfranchised, or the control of the affairs placed permanently in the hands of an unrepresentative assembly. It is well known that in many Divisions, if not in most, only a handful of members, chiefly residents in the towns where the meetings are always held, attend these meetings which elect and instruct Divisional Representatives. Men in most parts of the Division cannot neglect their patients in order to record their votes. This disability, special to medical men, must not be lost sight of in dealing with their representative government. Therefore the “Representative Body” as provided for in the Charter is a gravely unrepresentative body and discussions at which it arrives can in no sense be finally taken as the decision of the Association.³³

Even within the Representative body there were many that agreed. The Scottish Representatives were particularly strong in their objection. Dr Norman Walker³⁴

³¹ *BMJ*, ii, 1909, Supplement, p. 66.

³² *BMJ*, i, 1908, Supplement, p. 111.

³³ W. Gordon, *BMJ*, ii, 1908, p. 1520.

³⁴ Later Sir Norman Walker.

supported an amendment that proposed that Representatives should be elected by postal vote:

...because he knew that in the scattered districts of Scotland members had very rarely an opportunity to attend a meeting and could not do so as it would mean losing an entire day and perhaps more than one day. In the case of any important matter like the election of Representatives, he thought each member should have the opportunity of voting.³⁵

The Scottish arguments were not well received by the Council of the BMA.³⁶ 'In Scotland they live in a sort of heaven of their own and have no interest in common with the English members.'³⁷ Dr. Walker's proposal for postal voting was not put to a vote and was lost. The leaders of the BMA brushed aside all opposition. When expedient their methods could be dictatorial; in the preparation of the final draft of the Charter they attempted to overturn legitimate decisions of the Representative Meeting. The Representatives had wished to change the practice by which voting could only be done by show of hands. The Council resisted the change.

As a result of the of the Special representative Meeting in May 1907 certain resolutions for the proposed new Charter were passed, but some of them were considered by the Council not to properly represent the wishes of the Association. Consequently an instruction was issued to every Division throughout the Association that a direct vote should be taken on each resolution of the Representative Meeting.³⁸

This referendum, unauthorised by the Representatives Meeting was directed to all 220 Divisions. Replies were received from 149 Divisions in the UK and 10 from overseas. The total attendance at these meetings was 1,831 within the UK and 147 outside. The largest number attending any one of these meetings was 46, the smallest 2. The

³⁵ *BMJ*, i, 1908, Supplement, p.117.

³⁶ Described by the *Edinburgh Medical Journal* as the 'reverend seigneurs of the Association.' *Edinburgh Medical Journal*, NS i, 1908, p. 192.

³⁷ *BMJ*, i, 1908, Supplement, p. 111.

³⁸ *Ibid.*, p. 290.

meetings clearly demonstrated the general apathy of the members on political matters; even so, those who did attend voted decisively against the Council by majorities of at least 2 to 1.³⁹

There was little evidence that the leaders of the BMA could, with confidence, claim the substantial support of the membership. There was even less evidence that the leaders of BMA were justified in claiming the support of a majority of the medical profession in the United Kingdom, as was implied in the sophistical statement in the Petition: 'The present membership of the Association comprises upwards of 50 per cent of practitioners on the medical register'.⁴⁰ In 1908 when the petition for a Royal Charter was submitted to the Privy Council, 12,392 (49%) of the 25,017 medical practitioners registered in England and Wales were voting members of the BMA; in Scotland 1,825 (47%) of 3,829, and in Ireland, 862 (32%) of 2660.⁴¹

In the Petition to the Privy Council, the Council of the BMA, hoping to establish the Association as a political body, failed to make clear the extent to which the Association depended for its mere existence on its scientific journal. Not only was the *BMJ* responsible for the Association's reputation world wide, the journal also supported the Association financially. In 1907, for example, it was only the journal's income of £25,259, with a profit of £6,505, which saved the Association from a trading deficit. Very many members opposed any further advance of the Association's political activities that might cause them to overshadow its scientific reputation.

Despite the lack of united support from the membership and what on examination seems an insubstantial case, the leaders of the BMA persisted. At a meeting of the Representatives in July 1908, with only 107 of the 220 Representatives present, the motion to present the Petition for a Royal Charter was carried. The Petition was lodged on 21 December 1908.

³⁹ Minutes of the BMA.

⁴⁰ *BMJ*, i, 1909, Supplement, p. 2.

⁴¹ Figures from the *Medical Directory*, 1908 and *BMJ*, i, 1908, Supplement, p. 311.

The Privy Council, after deliberation, refused to grant a Charter. The British Medical Association made no further application. Indeed the *BMJ* makes no further reference to the Charter after 1909. The rebuff was received in silence.

The affair of the Royal Charter can be seen as a test of the right of the British Medical Association to manage and to represent the medical profession in Great Britain. In 1908 the BMA failed to establish that right. The BMA continued to be a limited company registered with the Board of Trade, neither a trade union nor with rights established by Charter. Nevertheless, the BMA went on to assume some of the powers it had been refused in 1908. From the disputes over the National Insurance Act until the difficulties in the creation of the National Health Service the BMA was uninhibited in its pretension to speak for the whole of the medical profession. In this it was so successful that in the end the identification of the BMA with the medical profession, in the eyes of the public, was almost complete.

Forgotten in the rest of the UK, the affair of the Royal Charter had a more lasting effect on the medical profession in Scotland. The facetious comment that 'in Scotland they were in a sort of heaven of their own' had drawn attention to the truth. As had been frequently pointed out by Scottish Representatives, the Scottish Divisions were exceedingly scattered and the Divisional structure that worked in England was unsuitable in Scotland. This had been illustrated by the response to the Referendum on the Charter. At two of the Divisional meetings called to allow members to record their votes no members attended and only one meeting in Scotland attracted more than 16 members. Of all members of the BMA entitled to vote in Scotland, only 12% were able to attend these special and important meetings.

At the final meeting of Representatives of the BMA before the Petition was presented, Dr. Walker of Edinburgh had made a final appeal. He asked that 'the same consideration should be shown to Scottish Divisions as to those in His Majesty's Dominions beyond the seas.' The Chairman ruled that this request could not be put to the meeting.

The *Edinburgh Medical Journal*, in its only reference to the Royal Charter affair, expressed the growing uncertainty about the relevance of the political activities of the BMA to the medical profession in Scotland.

It is evident that Scotland will gradually have less and less to say in the policy of the Association... Sooner or later Scotland will discover that the dominant partner resides south of the Tweed - a good way south.⁴²

⁴² *Edinburgh Medical Journal*, NS I, 1908, p. 193.

	1898	1903	1908	1913	1918	1923	1928	1933	1938	1948
Scotland.										
Population	4249	4579	4826	4728	4886	4901	4893	4912	4993	5169
Deaths	78397	76002	77838	73069	78372	63283	65271	64848	62953	60979
Death Rate	18.4	16.6	16.1	15.5	16	12.9	13.3	13.2	12.6	11.8
Births	130861	133525	131362	120516	98554	111902	96822	86546	88627	100344
Birth Rate	30.8	29.2	27.2	25.5	20.2	22.8	19.8	17.6	17.8	19.4
Infant Deaths	17554	15693	15900	13214	9836	8825	8299	7019	6163	4486
Infant Mortality Rate	134.1	117.5	121	109.6	99.8	78.9	85.7	81.1	69.5	44.7
Phthisis Deaths	7090	6130	6079	5103	5217	3996	3318	3810	2581	3415
Phthisis Death Rate	167	134	126	108	107	82	68	78	52	66
Puerperal Sepsis Deaths	227	303	241	160	113	218	234	212	150	30
Puerpeal Deaths	578	709	676	708	688	718	676	512	432	161
MMR	4.4	5.3	5.1	5.9	7	6.4	7	5.9	5	1.6
Sepsis Death Rate	1.7	2.3	1.8	1.3	1.1	1.9	2.4	2.5	2	0.3
England & Wales.										
Population	29,002	32527	35348	36919	37507	38403	39482	40350	41215	43502
Deaths	552141	514628	520456	504975	611861	526858	543664	579467	489100	468700
Death Rate	19	15.8	14.7	13.7	16.3	13.7	13.8	14.4	11.9	10.8
Births	923265	948271	940383	881890	662661	758131	660267	580413	621204	775306
Birth Rate	31.8	29.2	26.6	23.9	17.7	19.8	16.7	14.4	15.1	17.8
Infant Deaths	148013	124	113254	95608	64386	52311	42917	36566	32924	29461
Infant Mortality Rate	160	132	120	108	97	69	65	63	53	38
Phthisis Deaths.	41335	40132	39299	37055	42247	37627	34399	31860	21282	18798
Phthisis Death Rate	143	123	111	100	123	98	79	79	52	42
Puerperal Deaths	4367	3857	3361	3492	2509	3761	3733	3263	2096	809
Puerperal Sepsis Deaths	1707	1668	1395	1108	845	1246	1458	1949	682	187
Maternal Mortality Rate	4.7	4.1	3.6	4	3.8	5	5.7	5.6	3.4	1
Sepsis Death Rate	1.8	1.8	1.5	1.3	1.3	1.6	2.2	3.4	1.1	0.2

Sources: Annual Reports of the Registrar General for Scotland,
Annual Reports of the Registrar General for England Wales,
Annual Abstract of Statistics

Populations in thousands.

	1860	1865	1975	1885	1895	1905	1915	1925	1935	1945
Population										
Highlands	381,610	381,610	369,562	370,601	357,466	352,941	295,355	316,209	290,436	274,754
Ayrshire	199,063	199,063	201,168	200,908	229,883	254,468	264,335	306,458	289,442	207,631
Scotland	3,062,294	3,185,439	3,495,214	3,735,573	4,155,654	4,472,103	4,785,598	4,893,032	4,952,500	4,673,900
Deaths										
Highlands	5,698	6,081	7167	5,961	6,210	5,541	5,331	4,406	4,952	4,663
Ayrshire	4,054	4,053	5006	4,171	4,392	3,974	4,049	3,371	4,475	3,341
Scotland	63,539	70,821	81,767	74,607	81,852	74,536	81,631	65,507	65,331	62,655
Death Rate										
Highlands	14.9	15.9	19.4	16.1	17.4	15.7	18	13.9	15.4	12.2
Ayrshire	20.4	20.4	24.9	20.7	19.1	15.6	15.3	11	12.3	11.6
Scotland	20.7	22.2	23.4	19.4	19.7	16.7	17.1	13.4	13.2	13.2
Births										
Highlands	10,607	9,992	9186	9326	8,366	7,297	5,132	4,827	4,302	3,501
Ayrshire	7,464	7,538	8233	7623	7,564	7,824	6,689	5,947	5212	3,624
Scotland	104,418	113,126	123,578	126,100	126,494	131,410	114,181	104,137	87,928	86,932
Infant Deaths										
Highlands	906	935	919	749	704	681	452	284	234	146
Ayrshire	851	760	948	824	850	785	763	560	394	127
Scotland	12,622	14,099	14,950	15,200	16,874	15,275	14,441	9,430	6,754	2,932
IMR										
Highlands	85	94	100	80	84	93	88	59	54	53
Ayrshire	114	101	124	108	112	100	114	94	76	61
Scotland	121	125	132	121	133	116	127	91	77	60
TB Deaths										
Highlands	541	592	644	518	554	506	390	308	158	146
Ayrshire	586	502	569	476	409	344	260	138	116	127
Scotland	7264	7416	8699	7922	7,688	6374	5292	3722	2823	2,932
TB Death Rate										
Highlands	142	155	174	140	155	143	132	97	54	53
Ayrshire	294	252	283	237	178	135	98	45	40	61
Scotland	237	231	249	212	185	143	111	76	57	62

SCOTTISH BOARD of HEALTH

Sir George McCrae	Chairman, Local Government Board Member of Parliament for Edinburgh East.
Sir James Lieshman	Chairman, Scottish Insurance Commission Treasurer, City of Edinburgh.
Sir Leslie Mackenzie	Medical Officer, Local Government Board. Highlands and Islands Medical Service Board.
Dr. John McVail.	Deputy Chairman, Scottish Insurance Commission. Medical Officer of Health.
Ewen MacPherson, KC.	Legal Secretary to the Lord Advocate. Local Government Board.
Muriel Ritson	Secreatry, Women's Friendly Society.

CONSULTATIVE COMMITTEE on MEDICAL and ALLIED SERVICES
(1919)

O. Chanock Bradley	Principal, Royal (Dick) Vet. College, Edinburgh.
A.J. Campbell	Secretary, Berwick Medical Panel Committee.
A.K. Chalmers.	Medical Officer of Health, Glasgow.
D. Elliot Dickson	Convenor, Fife Colliery Surgeons Committee
J.R. Drever	Scottish Secretary, BMA.
Anne Gill	Lady Superintendent of Nurses, Royal Infirmary of Edinburgh.
Professor M. Hay	Aberdeen University.
J. Rutherford Hill	Secretary, Pharmaceutical Society in Scotland
Sir Donald McAllister	Principal, University of Glasgow
John Mackay	Principal, University College, Dundee
Sir James Mackenzie	Clinical Institute, St Andrews
Sir Robert Philip	University of Edinburgh
J. Maxwell Ross	Medical Officer of Health, Dumfries
Laura Stewart-Sanderson	Controller of Medical Services, Queen Mary's Army Auxiliary Corps.
Sir Harold Stiles	University of Edinburgh
F. Tocher	Public Analyst, Aberdeen
Norman Walker	General Medical Council
George Williamson	Chairman, Aberdeen Local Medical Committee
John Young	Vice-President, Odonto-Chirurgical Society

SCHOOL MEDICAL EXAMINATIONS

	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
School Population	762,132	816,004	819,537	831,792	827,311	841,991	823,445	808,110	795,079	782,872
Pupils Inspected	254,044	263,334	248,835	247,272	243,345	247,342	236,923	243,240	231,812	233,306
Proportion Inspected	33.33%	32.27%	30.30%	29.72%	29.41%	29.37%	28.77%	30.09%	29.15%	29.80%
Nutrition	6.1	6	6.2	5.5	5.7	5.5	5.5	5.1	5.5	5.3
Head Lice	1.8	1.7	1.4	1.3	1.2	1	0.9	0.9	1.1	0.8
Other Vermin	0.8	0.7	0.5	0.5	0.3	0.2	0.2	0.1	0.1	0.1
Hearing Loss	1	0.9	1	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Poor Sight (specs)	5.8	5.4	4.9	4.9	4.4	4.3	4.4	4.7	4.7	4.7
Skin Disease	3.7	3	2.8	2.9	3	2.9	2.7	3	2.8	2.9
Discharging Ears	2.4	2	2.1	2.3	0.9	0.9	0.9	0.9	0.9	0.9
Enlarged Adenoids	3.9	3.8	3.8	3.5	3.4	3.3	3.3	3.2	3.1	3.3
Rickets	1.6	1.4	1.3	1.4	1.2	1	1.1	1.1	0.9	0.8
Tuberculosis(overt)	0.1	0.1	0.1	0	0.01	0.02	0.02	0.04	0.03	0.03
Heart Disorders	1.9	1.8	2	2	1.9	2.2	2	2.1	1.9	1.8

Source: *Annual Reports of the Department of Health for Scotland.*

Recorded as percentage of children examined

	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
School Population	762,132	816,004	819,537	831,792	827,311	841,991	823,445	808,110	795,079	782,872
Number Examined	254,044	263,334	248,835	247,272	243,345	247,342	236,923	243,240	231,812	233,306
Dental Decay-number	187,203	188,547	180,654	178,035	172,531	173,139	165,324	171,484	165,745	165,647
Dental Decay	74%	72%	73%	72%	71%	70%	70%	71%	72%	71%
Number Treated	113,325	125,338	135,490	150,000	146,389	143,819	134601	152,670	146,491	149,920
Proportion Treated	61%	66%	75%	84%	85%	83%	81%	89%	88%	90%

Source: Annual Reports of the Department of Health for Scotland

Recorded as percentage of children examined

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| NAS HH 1/791 | (Letter: Collins to Chancellor) |

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NAS HH 61/787	(Legislation for Maternity Services)
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Sir Douglas Haddow, KCB.

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General Practitioner
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President, General Medical Council
President, British Medical Association
Professor of Medicine, Leicester

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Dr. James McHarg	Consultant Psychiatrist, Dundee
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Margaret Orr	Senior Nursing Officer, Western General Hospital, Edinburgh
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A. L. Rennie, CB.	Private Secretary to the Secretary of State for Scotland Secretary, Scottish Home and Health Dept.
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